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AUTHOR Hutchison, Mary Ann; And Others
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ABSTRACT

The Mental Health Prevention/Intervention Project (MHP/IP) was designed to provide and assess comprehensive and effective mental health services to Head Start children, parents, families, and staff. Sponsored by the Latin American Civic Association (LACA) in Los Angeles, the 14-month intervention was implemented and assessed on three levels: (1) staff training and consultation; (2) parent education and involvement; and (3) in-house mental health treatment services, including short-term psychotherapy. A comprehensive needs assessment survey was conducted to provide a profile of the Head Start families served by LACA. Out of 960 children and families in the program, 845 survey questionnaires were completed and returned. A follow-up questionnaire was completed later in the year on a sample of 220 families. Head Start teachers were trained to promote children's emotional development and social competence and to identify problems with the potential for long-range damaging effects. Bilingual parent education provided training to support parents as the primary educators of their children and to increase parent involvement in LACA Head Start activities. A team approach to mental health treatment encouraged parent involvement and teacher participation. Concluding remarks suggest that the success of the MHP/IP model warrants replication in other Head Start settings. Related materials are appended, including instruments and samples of treatment case summaries. (RH)

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OVERVIEW

STRENGTHENING HEAD START FAMILIES:
REDUCING HIGH RISK THROUGH MENTAL HEALTH PREVENTION/INTERVENTION (MHP/IP)

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Authors

Mary Ann Hutchison, Ph.D. - Project Designer/Director

Tomas Martinez, Ph.D. - Research Coordinator

Carlos F. Ortega, Ed. D.

Edison De Mello, M.S.

Sherry Robin-Deng, B.A.

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OVERVIEW

STRENGTHENING HEAD START FAMILIES: REDUCING HIGH RISK THROUGH MENTAL HEALTH PREVENTION/INTERVENTION (MHP/IP)

BACKGROUND

"Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention" Project (known as the MHP/IP throughout this overview) was designed to provide and assess comprehensive and effective mental health services to Head Start children, parents, families, and staff. The 14-month project was sponsored by the Latin American Civic Association (LACA) in Los Angeles, one of California's largest Head Start delegate agencies. The MHP/IP was supported through a grant from the 1984-85 Coordinated Discretionary Funds Program of the Office of Human Development Services, U.S. Department of Health and Human Services (OHDS/DHHS).

LACA is a non-profit educational organization comprised of 64 classrooms at 23 sites. LACA's total staff consists of 192 people, and its annual operating budget is $2.5 million. Of the 960 low-income families served by LACA, 70% are Mexican and/or Mexican American, 10% Caucasian, 7% other Hispanic, 7% Black, and 6% other; 53% of the families are monolingual Spanish-speaking.

The purpose of the MHP/IP was to deliver and assess the effectiveness of preventive mental health interventions on three levels: (1) staff training and consultation; (2) parent education and involvement; and (3) in-house mental health treatment services, including short-term psychotherapy. To accomplish these interventions, project staff did the following:

- Trained Head Start staff to promote emotional and social development of children and to become aware of early signs of problems that have the potential for long-range damaging effects;

- Provided in-house parent education to increase parenting skills and awareness of local services; and
- Provided in-house short-term psychotherapy to children and families, made appropriate referrals for adjunctive and long-term services, and involved parents and teachers in a team approach to service delivery.

THE PROGRAM

Staff

The project was staffed with one licensed mental health specialist and five full-time bilingual Spanish-speaking counselors. The mental health specialist was responsible for training and supervising the counselors and for training other LACA supervisory and support staff in order to familiarize them with project goals and procedures and to gain their support and involvement.

Needs Assessment

A comprehensive needs assessment survey was conducted early in the school year to provide a profile of the Head Start families served by LACA. The survey focused on four main areas: (1) family demographic information, e.g., income, ethnicity, language, etc.; (2) child's overall physical and mental health; (3) parental stress, social support, attitudes toward child-rearing, education, and other issues; and (4) parental knowledge and use of available community services.

Out of 960 children and families in the program, 845 survey questionnaires were completed and returned. A follow-up questionnaire was completed later in the year on a sample of 220 families.

Staff Training and Consultation

Through consultation teachers were trained to promote children's emotional development and social competence. Another function of consultation in the MHP/IP was to help teachers identify problems which had the potential for long-range damaging effects. All of the 960 children in LACA's 64 Head Start classrooms were observed for an average of 3½ hours by one of the mental health staff for the purpose of prevention, early identification and intervention followed by a two-hour training and consultation session with teachers. The result was early identification of children with problems and prompt referral to the mental health component. The mental health staff evaluated teacher performance and classroom environment, gave feedback on teaching, communication and behavior management skills and provided training and consultation in the areas needed. 89 percent of the teachers reported the training had been helpful to them.

Parent Education and Involvement

This part of the MHP/IP was designed to provide training to support parents as the primary educators of their children and to enhance the potential for parents to become involved with LACA Head Start activities. Parent education sessions were held at each Head Start site with most parents attending. The bilingual training focused on child development and social competence by providing strategies in self-help, problem-solving, and communication skills. The parent response to the sessions was quite positive. Family night presentations were attended by the entire family and covered topics such as parenting issues, normal growth and development, health issues and information on community resources. Activities for the children were provided. Parents were very concerned with the development of their children and were eager to improve their knowledge and skills.

In-House Mental Health Treatment Services

All of the parents and the staff received a detailed orientation to the MHP/IP which openly addressed the attitudes and stigmas attached to mental health. Children and families were referred to the mental health component by teachers, counselors, support staff, and parents. When a referral was received, a classroom observation took place, followed by a parent-teacher conference with a mental health counselor. The presenting problem was discussed, and the counselor explained the process for service delivery. Treatment began with a preliminary session with the parents and the counselor, followed by a screening session with the entire family.

The team approach allowed the parent to feel like an integral part of the treatment process. The more involved the teacher felt in the team approach, the more effective he or she was in providing an emotionally supportive environment for the child in the classroom.

On the basis of counselor's assessments, input and cooperation from teachers and parents, treatment goals were established. Recommendations were made for family, conjoint, individual adult, and/or play therapy, as appropriate. At this time, the need for adjunctive services was evaluated. All psychotherapy sessions were provided in-house by LACA mental health staff.

A final review was conducted eight weeks after the case was closed to assess treatment effectiveness and determine whether there was any need for further treatment.

MAJOR FINDINGS AND OUTCOMES OF MHP/IP

- o Of the 960 families in LACA Head Start, 76% did not have prepaid health insurance, and 73% had not used available community services.
- o The mental health component received 199 referrals representing 21% of LACA children and families, of which 121 (13%) received treatment.
- o In 75% of the 199 referrals, the original presenting problem was on the child (e.g., aggressive or withdrawn behavior, age-inappropriate behavior, etc.). After assessment, 84% of the presenting problems were on the

- parents/family (e.g., lack of parenting skills, intrapersonal conflicts, poor communication, marital problems, divorce and separation, etc.).
- Of the referred families, 49% were monolingual Spanish speaking, 32% monolingual English speaking, 17% bilingual English-Spanish, and 2% other.
- In the referred families, 57% of the children lived with both biological parents, 26% lived with the biological mother alone, 9% lived with one parent and another adult, and 8% were in another arrangement such as grandparents or foster parents.
- Of the families that received treatment, 59% were Mexican and/or Mexican American, 15% Caucasian, 11% mixed, 7% other Hispanic, 5% Black, and 3% other.
- Of the 121 families that were treated, average age of the mothers was 31 and average age of fathers was 33. Average educational level for both parents was eighth grade.
- Parents, teachers, and counselors rated treatments as successful in approximately 90% of the cases.
- Cost of the program was $100.00 per child per year (based on direct treatment costs of $96,000 and 960 children and families served).

CONCLUSIONS AND RECOMMENDATIONS

Project Head Start (1979) has stated that 10-25% of the children in Head Start suffer from serious psychological or developmental disturbances. This figure is consistent with NIMH estimates. Although Head Start serves a high-risk population, there have been no previous evaluations of the effectiveness of the mental health component in Head Start programs. Further, there has been no previous model for prevention, early identification and intervention that could serve as a framework for providing mental health services to Head Start children and families.

We believe that the MHP/IP is a program model that can be used to improve the delivery of mental health services to Head Start children and families and provide a basis for social and educational change. The MHP/IP model is based on the following concepts:

- The Head Start child is not viewed in isolation from the family. Rather, the family is considered an integrated unit and the emphasis is family-centered.
- Rather than focusing on deficits such as poverty, unemployment, and lack of education, the focus was on competency and building on the child's and family's strengths.
- The approach to treatment was ecological, considering the interactions of biological, social, psychological, and environmental factors as influences on children and families.
- The Head Start existing emphasis on cognitive development of children was shifted to an emphasis on social competence of children and families.

Several factors contributed to the success of the MHP/IP. First, the provision of in-house services increased the involvement of parents in the program and gave them a positive experience with a community-based provider of mental health services. Referrals were responded to promptly, in contrast to the one to three month waiting lists at many community counseling agencies.

Another important factor was the team approach, in which counselors, teachers, and parents worked together to direct the course of treatment. An unusual degree of cooperation was possible because the bilingual counselors were able to coordinate activities to ensure there was a consistent and emotionally supportive environment in the school and at home.

Perhaps the most important factor in our success was the commitment to a positive approach emphasizing family strengths, health, wellness, and prevention. In view of our experience, we urge Head Start to consider the following:

- Develop and implement policies to strengthen mental health in Head Start and emphasize prevention, early identification and intervention, through a multidisciplinary and family-centered approach.

- Shift the emphasis from a child-centered program to a family-centered program where the family is viewed as an integral unit.
- Emphasize and support the role of parents as the primary educators of their children and increase the amount of parent education that is available.
- Move beyond the deficit model to a competency model.
- Develop and implement policies that emphasize prevention, early identification and intervention, through a multi-disciplinary and family-centered approach.

The provision of comprehensive mental health services is critical in accomplishing the primary goal of Head Start, the promotion of social competence for children and families. The targeting of mental health funds within Head Start, and an emphasis on prevention, early identification and intervention is vital. More action is needed if mental health activities are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbances through early identification and intervention. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

FOR MORE INFORMATION REGARDING THE MHP/IP OR THE REPORT, PLEASE CONTACT:

Mary Ann Hutchison, Ph.D.
Project Designer/Director
MHP/IP
29 Navy Street
Penthouse
Venice, Calif. 90291
(213) 392-8037

FINAL REPORT

STRENGTHENING HEAD START FAMILIES: REDUCING HIGH RISK THROUGH MENTAL HEALTH PREVENTION/INTERVENTION (MHP/IP)

Authors

Mary Ann Hutchison, Ph.D. - Project Designer/Director

Tomas Martinez, Ph.D. - Research Coordinator

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In the course of conducting this project, the authors spoke with countless individuals who willingly provided information, shared concerns and gave us assistance. We are grateful to all of them for their enthusiasm and support in focusing on the mental health needs of Head Start children and families.

We also want to acknowledge individuals without whom the project could not have been accomplished and whose sustained help made the final report possible. In particular, we are grateful to the staff of the Latin American Civic Association: The administrative team of Ralph Arriola, Executive Director, Anne Hall, Assistant Director, and Romeo Crisolo, Fiscal Director; the counseling staff of Edison De Mello, Sara Benitez-Stanley, Sylvia Turk, Nina Gonzales, Gina Ross, Sherry Robin-Deng, and Virginia Baldioli; the supervisory, teaching and support staff; and the secretarial staff, particularly Violeta Ochoa and Bobbi Creamer. In addition, we wish to thank the secretarial staff of El Centro de Amistad, Ana Alvarenga and Aida Acosta. A special thanks to Cindy Siegel, who typed the final draft of the report.

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OVERVIEW

STRENGTHENING HEAD START FAMILIES: REDUCING HIGH RISK THROUGH MENTAL HEALTH PREVENTION/INTERVENTION (MHP/IP)

BACKGROUND

"Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention" Project (known as the MHP/IP throughout this overview) was designed to provide and assess comprehensive and effective mental health services to Head Start children, parents, families, and staff. The 14-month project was sponsored by the Latin American Civic Association (LACA) in Los Angeles, one of California's largest Head Start delegate agencies. The MHP/IP was supported through a grant from the 1984-85 Coordinated Discretionary Funds Program of the Office of Human Development Services, U.S. Department of Health and Human Services (OHDS/DHHS).

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MAJOR FINDINGS AND OUTCOMES OF MHP/IP

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- Of the 121 families that were treated, average age of the mothers was 31 and average age of fathers was 33. Average educational level for both parents was eighth grade.

- Parents, teachers, and counselors rated treatments as successful in approximately 90% of the cases.

- Cost of the program was $100.00 per child per year (based on direct treatment costs of $96,000 and 960 children and families served).

CONCLUSIONS AND RECOMMENDATIONS

Project Head Start (1979) has stated that 10-25% of the children in Head Start suffer from serious psychological or developmental disturbances. This figure is consistent with NIMH estimates. Although Head Start serves a high-risk population, there have been no previous evaluations of the effectiveness of the mental health component in Head Start programs. Further, there has been no previous model for prevention, early identification and intervention that could serve as a framework for providing mental health services to Head Start children and families.

We believe that the MHP/IP is a program model that can be used to improve the delivery of mental health services to Head Start children and families and provide a basis for social and educational change. The MHP/IP model is based on the following concepts:

- The Head Start child is not viewed in isolation from the family. Rather, the family is considered an integrated unit and the emphasis is family-centered.
- Rather than focusing on deficits such as poverty, unemployment, and lack of education, the focus was on competency and building on the child's and family's strengths.
- The approach to treatment was ecological, considering the interactions of biological, social, psychological, and environmental factors as influences on children and families.
- The Head Start existing emphasis on cognitive development of children was shifted to an emphasis on social competence of children and families.

Several factors contributed to the success of the MHP/IP. First, the provision of in-house services increased the involvement of parents in the program and gave them a positive experience with a community-based provider of mental health services. Referrals were responded to promptly, in contrast to the one to three month waiting lists at many community counseling agencies.

Another important factor was the team approach, in which counselors, teachers, and parents worked together to direct the course of treatment. An unusual degree of cooperation was possible because the bilingual counselors were able to coordinate activities to ensure there was a consistent and emotionally supportive environment in the school and at home.

Perhaps the most important factor in our success was the commitment to a positive approach emphasizing family strengths, health, wellness, and prevention. In view of our experience, we urge Head Start to consider the following:

- Develop and implement policies to strengthen mental health in Head Start and emphasize prevention, early identification and intervention, through a multidisciplinary and family-centered approach.

- Shift the emphasis from a child-centered program to a family-centered program where the family is viewed as an integral unit.
- Shift the emphasis from cognitive development of children to social competence and the emotional development and well-being of children and families.
- Emphasize and support the role of parents as the primary educators of their children and increase the amount of parent education that is available.
- Move beyond the deficit model to a competency model.

The provision of comprehensive mental health services is critical in accomplishing the primary goal of Head Start, the promotion of social competence for children and families. The targeting of mental health funds within Head Start, and an emphasis on prevention, early identification and intervention is vital. More action is needed if mental health activities are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbances through early identification and intervention. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

FOR MORE INFORMATION REGARDING THE MHP/IP OR THE REPORT, PLEASE CONTACT:

Mary Ann Hutchison, Ph.D.
Project Designer/Director
MHP/IP
29 Navy Street
Penthouse
Venice, Calif. 90291
(213) 392-8037

EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

Introduction

This Executive Summary will present, analyze, and discuss the findings of the final report from the mental health demonstration and research project entitled,"Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention" (referred to as the MHP/IP [Mental Health Prevention/Intervention Project] throughout the remainder of this report). The project was submitted to and funded by the U.S. Department of Health and Human Services/Coordinated Discretionary Funds Program for fiscal year 1984/1985. The Latin American Civic Association (LACA) was the recepient of this 14 month grant which covered the period from August 1984 to September 1985. LACA, a non-profit organization, is one of the largest Head Start delegate agencies in the state of California and currently serves 960 children and families at 23 sites, 64 classes, and has a staff of 192 people. The MHP/IP was staffed with a licensed mental health specialist, 5 counselors, and a research team.

The concept of prevention, which was integral to the MHP/IP, has 3 levels of action. As stated by Leavell and Clark, "In public health terminology, prevention is an all embracing concept having three distinct levels: primary prevention, referring to actions taken prior to the onset of disease to intercept its causation or to modify its course before man is involved; secondary prevention meaning early diagnosis and treatment; and tertiary prevention, indicating rehabilitative efforts to reduce the residual effects of illness (Goldston, 1977:19)."

The MHP/IP assessed the effectiveness and proposed a model of mental health treatment service delivery to a high risk Head Start population. Three preventive mental health interventions were tested: 1) staff training and consultation, 2) parent education and involvement, and 3) in-house mental health treatment services, including short-term psychotherapy.

The first intervention, staff training and consultation, was designed as a primary prevention strategy to provide services to teaching and service component staff on the implementation of mental health skills to increase their job effectiveness. The second intervention, parent education and involvement was also designed as a primary prevention strategy to provide training and needed skills to support parents as the primary educators of their children, as well as to empower parents to participate in Head Start activities, and in the lives of their children and families. The third intervention, in-house mental health treatment services, including short-term psychotherapy, provided secondary prevention, early identification, and intervention of children and families with problems, as well as encouraged prompt referral to mental health and/or appropriate components. The counseling staff provided in-house short-term psychotherapy which offered the opportunity to reduce social or psychological dysfunctions which had the potential to produce long-range damaging effects.

The research aspect of this study was carried out through the utilization of a series of instruments which enabled the reseachers to collect three types of data. The first type of data collected was through the implementation of a needs assessment and follow-up. The needs assessment was designed to provide information regarding the needs, social history, and special circumstances impacting upon the child and family. Information regarding problems of high risk and utilization of human services provided an understanding of the systems about which families are aware. The needs assessment was administered to 960 families participating in LACA's Head Start program. The final returns yielded a sample population of 845 completed interviews.

The follow-up assessment, implemented with a sample of 220 families, provided baseline comparisons with the needs assessment population. More importantly, the document provided data on any changes encountered by the family during the year in Head Start. A second type of data collected by the researchers was provided by the Family Social Competence Survey. The MHP/IP wanted to identify factors associated with the social competence of the family which would assist in early identification and early intervention. By focusing on the strengths of families, this survey underscored the need for human service professionals to work with families as partners. A third type of data was obtained on 199 children and families who were referred to the mental health component. The documents provided data on demographics, treatment and outcome evaluations on individual cases, and was gathered from counselors, teachers and parents.

Another important aspect of the MHP/IP was the utilization of the ecological model with its broader base over the less effective deficit models. In the MHP/IP, the child and family were viewed from a holistic systems orientation. A multi-vectored ecological model of treatment was used combining biological, psychological, social, and environmental factors. In essence, the MHP/IP focused on working with family strengths not deficits; that is, parents were seen as partners with program staff working together to enhance child and family development.

The ecological model addresses the whole person: the internal and external factors which comprise an orientation to the interrelatedness of one's self and one's environment. Deficit models, on the other hand, tend to assume low-income families are poor because of a set of social and psychological conditions which keep them at these levels. Although these models gained influence during the War on Poverty, critics have established that deficit models "blame the victim" for their problems and do not address the inegalitarian structures of society which helped to foster these conditions. Instead, the MHP/IP proposed to view a person from a multi-vectored ecological perspective.

The primary goal of Head Start is the promotion of social competence. To date, approximately 80% of the Head Start population are enrolled in center-based programs with a primary focus on a cognitive oriented education in which program components serve the education component. 20% of the population are enrolled in home-based family oriented programs.

The MHP/IP proposed a shift from a program which has primarily emphasized cognitive development to a program which focused on the promotion of social competence in Head Start children and family, and where all the components including the education component, serve the Head Start child and family. When viewed from an ecological perspective, this basic premise assumes the child is not a cognitive entity alone but an individual with a physical body, a social and emotional essence, and must be viewed as an integral being who interdependently relates to his family, community and society.

To date, there have been few research studies undertaken to show the effects of mental health service delivery in Head Start programs. A report, Head Start in the 80's (HHS, 1980) recommended a shift from a child-centered to a family-centered program. The effectiveness of the proposed MHP/IP model, which is in keeping with this recommended shift, portends that for education and human service delivery on a national level, the child no longer be viewed in isolation from the family. Rather, the family should be considered as an integrated unit.

The potential for prevention and treatment services in the area of mental health for Head Start children and families has been recognized as critical. Research shows that 10-25% of Head Start children were thought to suffer from serious developmental and psychiatric disturbances (Cohen, Solnit, Wohlford, 1979). The theory of prevention asserts that through early identification and intervention the high incidence of severe problems and the potential for long-range damaging effects will be reduced. And yet, no model for prevention, identification and intervention has been demonstrated as an effective strategy for mental health service delivery to a Head Start population. The MHP/IP proposes to provide a model for prevention, early identification, and intervention which can be adapted, replicated, and become the state of the art for mental health in Head Start, and provide a model for national change in the educational system.

The Executive Summary presents findings related to the three preventive mental health intervention strategies:

- o staff training and consultation to increase job effectiveness on implementing mental health skills;
- o parent education and involvement to support parents in their role as the primary educators of their children;
- o in-house mental health treatment services which include short-term psychotherapy, prevention, early identification and intervention for children and families with problems.

The following sections of this Executive Summary describe the background and methodology for the MHP/IP, followed by a presentation of the major findings. The final section is a discussion of the program and policy implications of the project findings.

BACKGROUND

The Objectives of Head Start

To understand the origins of Head Start, one must also consider the times in which it came about: the civil rights struggles for social and political justice, the War on Poverty, social intervention strategies for the poor and disadvantaged, and a renewed interest in the role of the environment in human development (Zigler and Valentine, 1979:3). It was a time when the need to prepare children to succeed in school gave Head Start its impetus. Utilizing existing evidence, early planners suggested that a large scale intervention had to include cognitive approaches, parent involvement, medical needs, and nutritional activities (Cooke, 1979:xxiv). This work produced seven original goals which would guide Head Start (Richmond, Stipek, Zigler, 1979:137):

1. Improving the child's physical health and physical abilities;
2. Helping the emotional and social development of the child by encouraging self-confidence, spontaniety, curiosity, and self-discipline;
3. Improving the child's mental processes and skills, with particular attention to conceptual and verbal skills;
4. Establishing patterns and expectations of success for the child that will create a climate of confidence for future learning efforts;
5. Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems;
6. Developing in the child and his family a responsible attitude toward society, and encouraging society to work with the poor in solving their problems; and
7. Increasing the sense of dignity and self-worth within the child and his family.

Head Start had five original components which suggested an ideological direction, counteracting the culture of poverty view that physical and mental health was directly linked to the circle of poverty and poor educational achievement:

1. Medical and dental services for poor children;
2. Social services for the child's home environment and family, since home and family were considered responsible for low educational achievement, family intervention was seen as logical;
3. Psychological services which emphasized staff consultation and community consultation rather than testing and clinical activities, as well as help develop parent involvement and community participation;
4. School readiness programs that emphasized preparing the child to enter school on equal terms with other children; and
5. Volunteer services which would enable parents to participate fully in Head Start programs (Spring, 1976:222).

Beyond Deficit Models of Social Policy

The use of deficit models such as the culture of poverty have been very influential in formulating social policy. Yet, despite the continued influence of these models on policy, social scientists (Baratz and Baratz, 1970; Leacock, 1971; Ryan, 1976) have criticized these models for methodological reasons such as neglecting the cultural patterns of the poor as a means of finding solutions to their conditions. Stipek, Valentine and Zigler (1979) write: "It seems evident now that preschool intervention with the disadvantaged cannot be expected to contribute to the elimination of poverty, since poverty in America has its roots in other, noneducational aspects of American society (p. 480)."

Recently, a new perspective has arisen which calls for a shift in policy and with it, a new perspective towards children and families. The call is for policies which counteract conditions that affect the family's ability to cope with their environment; a call for policies which go beyond deficit models. Bronfenbrenner and Weiss (1983) suggest the concept of the ecology of human development defined as the "scientific study of the progressive, mutual accommodation between the developing person and the changing properties of the immediate and broader contexts in which the person lives (p. 393)."

A report published by the U.S. Department of Health and Human Services (1980) suggests a shift from a child-centered approach widely used in Head Start to a family-centered approach. To date, this has been a theoretical shift which has not been actualized in programming. For one thing, many of the child-centered programs which still exist originated in the maternal and child study groups developed during the progressive era of American education in the 1920's and 1930's (Cremin, 1964; Lightfoot, 1978; Button and Provenzo, 1983). Based on the ecology of human development, the findings found in this summary represent a sound step in the development and delivery of comprehensive mental health services to children and families in Head Start. The MHP/IP proposed a comprehensive model for mental health service delivery, relying on all Head Start components for its success and most importantly, saw the role of parents as a major aspect in its contribution to strengthening child and family competence.

Development and Practice of Mental Health in Head Start

Since 1965 Head Start has grown into the largest comprehensive child development program in the United States. There have been great variations among regions of the country, differences in the interests and style of local program administration, and varying concerns of Head Start directors. In spite of variation, the national Head Start program could be said to have placed its greatest emphasis on the preschool child's achievement of lasting intellectual skills throughly early cognitive oriented education. In comparison, there has been little explicit attention given to the child's emotional development and psychological difficulties. Head Start has undergone a variety of changes over the years, but of all the components, what was originally known as psychological services and now known as mental health, has been the least visible, least adequately funded and least valued (Cohen, et.al., 1979).

For the most part, the mental health components in Head Start receive referrals on children in the program and then refer them to outside agencies. However, research has shown this low income population will rarely use available community mental health services. The reasons include their belief the family should be able to manage its own affairs, their distrust of bureaucracy, and for the increasing number of ethnic minorities, the lack of bilingual and culturally sensitive counselors (Barrera, 1978). Mental health services to children, families and minorities typically receive the lowest priority in funding (Childrens Defense Fund, 1982). Low income families and their children experience more stress and therefore, a greater potential for high risk in health and mental health disorders than the typical population of preschool age children and their families. The President's Commission on Mental Health (1978) indicates extensive evidence has led to the conclusion poverty increases the risk for serious psychiatric and developmental disturbances. Almost any disorder - schizophrenia, alcohol and drug addiction, retardation, depression, epilepsy, severe learning disturbance and delinquency - is more likely to occur with a high risk population. Research also shows 10-25% of Head Start children were thought to suffer from serious developmental and psychiatric disturbances. Cohen, et.al., (1979) indicates that:

> The consensus among clinicians was that if many of these Head Start children were seen in private practice consultation and were from middle-class families, serious developmental and psychiatric disturbances would be diagnosed. Did the symptoms and signs of developmental delay and irregularity have a different meaning in the offspring of the poor (p. 206)?

It is estimated that two million of the three million seriously emotionally disturbed children (66%) in this country do not get the mental health services they need (Children's Defense Fund, 1982). This figure does not even begin to take into account the children who are beginning to show signs of emotional problems.

The main goal of Head Start is, according to Zigler and Valentine (1979), to increase social competence in children of low-income families. The performance standards state the goals and objectives for the Head Start program and provide a set of guidelines for service delivery. However, the goals and objectives of these standards have been interpreted in a number of ways. As stated, Head Start has focused primarily on a cognitive approach, thus there has been little understanding and, therefore, implementation of the original goals of the Head Start program. In addition, there has been little comprehension of the goals of mental health in Head Start for reasons which include stigmas attached to mental health, educationally oriented administrators; and, after 20 years of Head Start, only two mental health professionals have been responsible for mental health at the National Head Start Bureau for less than 5 years. Cohen et. al., (1979) writes, for example:

> The extent of the undervaluation of psychological expertise can be brought out most dramatically by comparison with the educational component. For example, throughout its history, Head Start was heavily engaged in the development of

> preschool curricula. Large sums were spent on writing new curricula, implementing them, and evaluating their short and long-term cognitive effectiveness. In this process, educators were central to the Head Start program at all levels. In contrast, Head Start administrators showed relative apathy toward the special knowledge of mental health professionals working with families in improving children's self-esteem, in detecting emotional difficulties, in altering communal values, in treating sick children, and in other potentially critical aspects of relevant concern (p. 278).

Since accountability for quality programming has not been built into the system, agencies have run maintenance mental health programs in order to meet compliance. It has been observed by the authors that within Head Start, one person usually supervises two or more components (i.e., one person may supervise social services, handicap, and mental health). In fact, the authors have consistently observed, in these cases, that mental health has been the component which has received the least attention. In 1985, as a typical example, one agency serving over 800 children reported having a $60,000 dental budget, a $62,000 handicap budget, and a $5,000 mental health budget.

According to current federal guidelines, Head Start can either hire a mental health professional or a mental health coordinator (para-professional). Usually both of these people contract with mental health consultants who are the direct providers of mental health services to children and families. However, in-house psychotherapy is rarely provided. The authors have found for the most part, the services given have not met the needs of this high risk population due to the following:

1. Head Start has attracted consultants who many times have lacked experience with Head Start, preschool children, families, minorities, and high risk populations;

2. Consultants have generally lacked an ongoing relationship and involvement in the overall Head Start program and have provided minimal hours of services;

3. There has generally been little accountability built into the system for quality services and follow-through. Therefore, insufficient, and ineffective service delivery have resulted;

4. Mental health staff has generally not had the needed bilingual language capabilities and cultural sensitivity, to serve the growing number of non-English speaking populations.

Latin American Civic Association's Mental Health Program Development, Treatment Ideology and Service Delivery

In the MHP/IP, the child and family were viewed from a multi-vectored ecological model of treatment combining biological, psychological, social and environmental factors in order to adequately address the cause of a problem. For example, if a child were referred to mental health for aggressive behavior, the counselor assessed if there were biological or organic factors precipitating the aggression. The psychological well being of the child, the siblings and the parents were evaluated in assessing the problem; and the social structure, extended family, cultural and societal pressures were also assessed to see how they affected the child and the family.

Parents were viewed as the primary educators of their children. Family strengths and problems were viewed from the standpoint of cause and effect. In focusing on the child alone (who usually manifested the effect and/or symptom of the family dynamics), the origin of the problem rarely was resolved. One of the program's objectives was to show that as parents underwent changes, those changes directly affected the children and entire family. This point underscored the need for a shift from a child centered program to a family centered approach. In addition, the MHP/IP provided staff training and consultation to increase teacher's skills in fostering an emotionally healthy and supportive classroom environment. Focus was also placed on promoting positive attitudes toward mental health, and shifting the existing focus in mental health from pathology to health and wellness. Counselors were employed who were bilingual and culturally sensitive to their client's needs.

The MHP/IP provided a model for prevention, early identification, and intervention. In this study, the goal of primary prevention was to enhance parent-child-teacher interactions, both in the classroom and in the home. The provision of parent education, the use of volunteer parents as part of the mental health component, and an increase in the utilization of helping services by Head Start family members were used as a means of directing parents, and therefore their children, toward improved social competence in the enhancement of their own lives.

Secondary prevention occurred through early diagnosis and treatment. During the early months of the program, all 960 children received a 4 hour observation in each classroom followed by a 2 hour training and consultation with the teaching staff. The mental health counselor and the Child Development Specialist (CDS) did a joint supervision/observation cycle. The result was early identification of children with problems and prompt referral to mental health and/or appropriate components. As a result, children were referred to the program for services including in-house short-term psychotherapy with their families. Counseling staff provided early intervention which offered the opportunity to identify and reduce social or psychological dysfunctions which traditionally have not been addressed on this level.

Referrals were initiated by the teaching staff, parents or support staff. If the referral were on a child, a mental health counselor consulted with the teacher, observed the child in the classroom, conducted a parent/teacher conference to discuss the problem and to explain the mental health services and process. A preliminary session with the parents alone, followed by a screening session with the entire family took place. Any adjunctive services, needed to evaluate the problem were also provided at that time, (i.e., medical evaluation, referral to handicap services, and/or appropriate components). The case was then staffed and recommendations were made for treatment. An interpretive session was held with the parents and a decision was jointly reached as to the course of treatment. Family, conjoint, play, and individual adult therapy were provided. A plan was made to train the teacher and support the child in the classroom. Eight weeks after the case was closed a final review was conducted to evaluate the status of the case and determine whether the results of therapy were successful or whether additional treatment was needed.

Tertiary prevention indicates rehabilitation efforts to reduce the residual effects of illness. Children who needed long-term intervention were referred to handicap services. The mental health and the handicap components coordinated service delivery to these children and families. Those families that are thought to benefit from continued therapy were encouraged to do so and are referred to the appropriate agencies.

A mental health program that serviced a mainstream population could emphasize primary prevention. A mental health program that services primarily a high risk population must go beyond tradition. If only traditional preschool programs were offered to high risk populations, then the children would not have a "head start" in the educational system nor in life. Concurrently, if a traditional mental health program emphasized primary prevention, there would be no remediation offered to the severe problems our population is faced with. Head Start provides a short-term, one year intervention into the lives of high risk children to prepare them for the educational system. This is what a mental health prevention program should do.

MHP/IP Emphasis On Social Competence

Head Start's performance standards state that social competence is the primary goal of Head Start. Due to Head Start being primarily focused on a cognitive approach, no clear definition and operationalization of social competence as an effective way of measuring the gains of Head Start in children have been explored (Zigler and Trickett, 1977).

An effort of the MHP/IP was to define social competence and develop measures to assess the social competence of children and families. The MHP/IP's overall goal for social competence was to strengthen child, and family self esteem, individual responsibility, personal integrity, creativity, interdependence, an individual's everyday effectiveness in dealing with the environment, and a concern for the whole. The project focused on strengthening the family's life and supporting the relationships between the child, the family, the Head Start program and the community. In addition, the second aspect of social competence, the ability of the child and family to adapt functionally through the acquisition of new skills for living, was also emphasized. The authors believed that by reducing the psychological dysfunction in children and families who were referred to the mental health component, these families would be able to function more adaptively and learn effective problem solving skills. The early identification and treatment of high risk factors, which have the potential to cause long range damaging effects, were believed to allow family members to better interact and respect one another, know the importance of their role in the family, and support their children in everyday experiences.

In addition to promoting social competence by reducing high risk which was partially assessed through the reduction of psychological dysfunctions, the authors wanted to use a pre- and post test and social competence index to measure the reduction of high risk. However, because of the brevity of the study (14 months), these goals were not accomplished. The authors will continue the development of this analysis at a future date.

METHODOLOGY

Procedures

The following were the procedures utilized by the authors in testing the intervention strategies of staff training and consultation, parent education and involvement, and in-house mental health treatment services:

1. Staff Training and Consultation

Goals

The goals for staff training and consultation were: (1) to orient the staff to the implementation of the MHP/IP for the purpose of understanding and supporting the project, knowing their role, understanding the staff training and consultation process, procedures for referrals, and procedures for mental health services; (2) facilitate the staff's positive attitude toward mental health services; (3) promote early identification of children with problems and prompt referral to mental health and or appropriate components; (4) provide direct training to teaching staff in the area of promoting an emotionally supportive environment in the classroom; and (5) provide training to teaching staff in the areas of child growth and development, observation techniques, effective communication, behavior management, and strategies for dealing with specific child behaviors.

Objectives

The objectives for the staff training and consultation were: (1) to increase the utilization of mental health services measured by an increase in the number of referrals received by the mental health component (measured by the number of referrals); (2) to reduce child psychological dysfunction by training the teaching staff on the uses of effective behavior and emotional classroom management skills (measured by Mental Health Individual Child Observation/Action Plan and 8 week review); and (3) to increase the teaching staff's confidence in their abilities to handle their classrooms (measured by teacher feedback to cycles).

Procedures

The following were procedures used for staff training and consultation: (1) MHP/IP staff orientation; (2) Mental Health Classroom Observation/ Supervision Cycle; and (3) Mental Health Individual Child Observation/Action Plan; and (4) Staff Evaluation of Mental Health Services.

2. Parent Education and Involvement

Goals

Parents bring their children to Head Start for assistance in preparing them for future participation in public education. In this process, parents are introduced to a myriad of services, committees, rules and regulations, and other structural factors which are presented as vehicles in completing their children's "head start". The MHP/IP project developed activities which would enable parents to work as partners with Head Start teachers and staff in achieving the total development of the child and family.

Objectives

The objectives of parent education and involvement activities were to provide training of parents in parenting skills and child development in order to reduce the potential for high risk. In addition, community resources would be mobilized, parent participation increased in order to provide social support and enhance coping mechanisms within Head Start families.

Procedures

There were three original procedures organized as part of the study: 1) parent education sessions; 2) monthly family nights; and 3) parent education/support staff training.

3. In-House Mental Health Treatment Services

The primary goal and objective of treatment services was to provide prevention, early identification and intervention in problems that interfere with a child and/or family's social and psychological development for the purpose of fostering social competence.

Goals

The goals for treatment services were: (1) to strengthen family life and support parents as the primary educators of their children; (2) to promote social competence in the child and family; (3) to support relations between the child, family, Head Start program and community; and (4) to develop a positive attitude towards mental health services.

Objectives

The objectives for treatment services were: (1) To reduce psychological dysfunction in children and families that were referred to the mental component through prevention, early identification and intervention (measured by findings of case summary); (2) To increase utilization of mental health services to the mental health component (measured by the number of referrals received); (3) To switch the focus of mental health service delivery from a child-centered program to a family-centered program (measured by original presenting problem and presenting problem after assessment).

Procedures

Treatment services were in two steps (1) assessment and, (2) treatment/short term psychotherapy.

1. Assessment

The following were the stages of assessment of the problem: (a) mental health classroom observation/supervision cycle; (b) referrals; (c) classroom observation; and (d) parent/teacher conference. All of the children in the program received an initial classroom observation for purposes of early classroom identification and referral to the mental health and/or appropriate component. When a mental health referral was received on a child, a classroom observation was made. This was followed by a parent/teacher conference at which time the parent, teacher, and mental health counselor discussed the problem and were then (parents) scheduled for a preliminary session.

2. Treatment/Short-Term Psychotherapy

The following were stages of treatment/short-term psychotherapy: (a) preliminary session; (b) screening session; (c) staffing/treatment plan; (d) interpretive session; (e) continuation of treatment; (f) case closing; and (g) final review.

At the preliminary session, parents met with the mental health counselor to more intensively discuss the history of the presenting problem, learn about the services, and process of the mental health component. This was followed by a screening session at which time the parents, referred child, siblings, and other members of the household, come together for the initial family session to assess overall family dynamics, parenting responsibilities, communication patterns, alliances, limit setting, etc. Any other needed evaluations were done at the time. The case was then staffed. The entire assessment was taken into account when formulating an appropriate treatment plan. At the interpretive session, the mental health counselor and parents jointly reached a recommendation for treatment. The teaching staff was also trained to assist the child in the classroom. After the case was closed, a final review was conducted eight weeks later to measure the success of treatment. If other problems had arisen, the family could, if necessary, come in for further treatment.

Sampling

The target population for this study were the 960 families who participated in the Head Start program during the 1984-1985 school year. Data from three sample populations are presented based upon the needs assessment, follow-up assessment and reported treatment outcomes. Every family had the potential to participate in the needs assessment survey. All 64 sites were represented in the analysis of the findings. Of the 960 families contacted, 845 surveys were completed and returned.

The follow-up assessment survey utilized a sample of 220 families. Site selection for this follow-up assessment was based on those sites reporting a higher number of referrals to the mental health component. All families and children had the potential to be identified as requiring services. Teachers, parents, and support staff served as the three primary referral sources. 199 mental health referrals were made.

Instrumentation

8 instruments were used for the purpose of analysis. The intent of these instruments was to provide a systematic outcome analysis of the amount and type of social need, and the level of social competence. Outcome measures related to staff training and consultation and mental health services delivered, provided information used to assess the impact of these services. These instruments include 1) Needs Assessment and a Follow-up Assessment; 2) Family Social Competence Survey; 3) Mental Health Classroom Observation/Supervision Cycle; 4) Teacher Feedback on the Mental Health Observation/Supervision Cycle; 5) Mental Health Individual Child Observation/Action Plan; 6) MHP/IP Parent Evaluation of Mental Health; 7) Mental Health Intake Form; and 8) Case Summary Form.

DEMOGRAPHICS OF THE POPULATION

Needs Assessment Data

The needs assessment was designed to elicit information on the needs, problems, and status of the children and families participating in Head Start. The instrument reflected four areas of concern to Head Start: 1) family information; 2) the child; 3) family issues; and 4) service utilization. Family information was designed to provide data on the family, such as the type of residence, number of adults and children in the household, whether or not families had friends or family members within the community acting as support systems. Information on the child was elicited from parents on the child's overall health, sleeping and eating habits, and child care outside the home. The section on family issues asked questions regarding the parent's feeling toward themselves such as life satisfaction, problems which present themselves on a daily basis, and the child's reaction to family disagreements. Lastly, the researchers wanted to know the degree to which parents utilized human services, their knowledge of specific agencies, and what type of information or services they felt were needed at the present time.

Demographics

The average age of LACA's Head Start parents was 28 years old. Age groups ranged from 19 years of age to 63 years. It was deduced that parents whose ages ranged in the late 50's or early 60's were not always parents of the Head Start children but legal guardians.

Family and Friends in Community

These questions were concerned with support systems available to family's as a means of coping with problems or concerns to a family. Such systems could mean having someone to care for the child, one who offers advice in certain situations or provides a certain ambiance which enables the family to cope. Of the respondents, 374 or 45% of the population responded they had a few family members. 205 or 25% responded they had many family members, while 249 or 30% answered they did not have any family (see Table 1).

With friends in the community, 493 or 59% responded they had a few friends. 269 or 32% answered they had many friends in the community. 69 or 9% did not have any friends in the community.

Table 1

Presence of Family and Friends in the Community

	Family in Community (N=828)	Friends in Community (N=831)
Present in Community		
Yes, alot	205/25%	269/32%
Yes, a few	374/45%	493/59%
None	249/30%	69/9%

Language

The LACA Head Start program has historically served a large percentage of Spanish speaking people. As indicated by language of preference, this assumption continues to appear true. Of those who responded to this question, 467 or 64% chose to speak only Spanish; 164 or 22% spoke only English; 92 or 12% spoke English and Spanish, and 17 or 2% spoke another language (see Table 2).

Table 2

Language Preference of Head Start Families

N=740

	Frequency	Percentage
Monolingual Spanish	467	64%
English	164	22%
Bilingual English/Spanish	92	12%
Other Languages	17	2%
Total	740	100%

Child Problems

Parents were asked a series of questions regarding their children's overall health. Researchers were concerned with identifying existing problems in order to discover if parents would utilize Head Start's referral system. In general, the questions focused on sleeping and eating habits.

One question that appeared to be constant was a parent's perception of a problem compared to the assessment by a human service professional. Parents, for example, were asked if their children were in good health. Not surprisingly, 798 or 96% of the parents who responded to this question felt their children were, in fact, in good health, 28 or 3% of those who responded felt there was a problem with their child's health, while only 3 individuals chose not to respond.

The research team then asked if children had received a physical exam in the previous twelve months. The data revealed a larger distribution of responses among the population. 63% or 519 of those who responded stated their children had received a physical exam, 69 or 8% of the parents stated their children were taking one form of medication. This could have been a simple aspirin or prescribed form of medication. Again, it should be noted the researchers were interested in the parent's perception of a child's problem. 752, or 91% were not taking medication while 4 parents chose not to respond.

Follow-up Assessment Comparisons

The findings showed some changes had occurred with the population over the school year. For example, in the needs assessment, the researchers asked if parents participated in a pre-paid health plan. 72% responded they did not, while 27% said they did, 19% did not respond. It was assumed not having prepaid insurance was definitely courting a possible high risk situation (see Walden, Wilensky, Kasper, 1985). This situation did not change over the year. Even the smaller sample of the follow-up assessment showed a high percentage without pre-paid insurance: 89% without insurance as compared with 9% with insurance, 2% did not respond (see table 3).

The health of the child seemed to remain stable according to parent's perceptions. As reported in the need assessment, 96% of the parents reported their children in good health. In the follow-up assessment, 94% of the parents reported their children as being in good health, with 6% of the children not being in good health. Data on whether or not the child had received a physical exam also remained constant. In the needs assessment, 63% of the parents reported their children had received physical exams while in the follow-up assessment, 87% of the children had received physical exams, compared to 37% and 12% respectively who had not. A related finding from the follow-up assessment seemed to confirm the fact children were in good health.

Table 3

Availability of Prepaid Health Insurance
Needs/Follow-up Assessment Comparison

Do you have a Pre-paid Health Plan?	Need Assessment N=804	Follow-up Assessment N=221
Yes	214/27%	20/9%
No	581/72%	197/89%
No Response	9/1%	4/1%

Social Competence Survey

The MHP/IP had as one of its goals the identification of factors associated with the social competence of the family, which would serve to enhance the ability for early identification and intervention with Head Start families. It would also serve to indicate the relative strength of the family in coping with daily life. This was probably the most important reason for conducting the survey of social competence: To point out the strengths of families underscores the need for human service professionals working with families as partners not as individuals with some cultural deficiency. Thus, the four factors identified by the research team for the survey were: 1) language use and bilingualism, 2) family needs, 3) interest in community affairs, and 4) parent attitudes towards education.

An important aspect of social competence was the degree to which parents were aware of, and utilized, social service agencies. It was assumed that knowledge of and use of these agencies could help to minimize high risk. The researchers provided a list of 10 existing social service agencies. Parents were asked to note if they were aware of any of the agencies on the list and if they were not, could they give the name of a similar agency. Parents were generally not aware of the listed agencies. This brings up important implications since it has been documented how low-income Latino families do not utilize human service agencies. When asked if they had used any of these services, 192 (27%) of the parents said they had, while 515 (73%) said they had not. This response changed dramatically when parents were asked if they would ever use these services. 470 (76%) said they would while 146 (24%) said they would not.

Parents were then asked about specific services they might feel a need for. They could respond in 4 ways: just need the information, have utilized in the past year, need the service now and no need for service. In table 4, there is a listing of the services given to the parents. The majority of respondents indicated there was no need for services which can be interpreted in different ways. For one, these respondents may perceive that internal family problems do not exist which require the services of social service agencies. There may be the belief families should be able to cope with any issue at a given time. It could also be due to a family's perception that stigmas would be attached to them by asking for help from a human service profesional. The next highest group responded with a need to acquire information in order to be aware of available services. These individuals were followed by the group who needed services immediately. Lastly, the smallest group had previously utilized various services.

Table 4

Reported Needs of Head Start Families

	Need Service Information #	Services Utilized In Past Year #	Need for Service Now #	No Need for Service #
Financial Needs (N=553)	46	7	29	471
Spouse Abuse (N=554)	23	6	6	519
Child Abuse (N=554)	26	3	8	517
Alcohol/Drug Abuse (N=554)	27	6	9	512
Psychological Services (N=550)	43	11	21	475
Crisis Intervention (N=551)	56	8	29	468
Medical Needs (N=557)	110	14	58	375
Shelter (N=557)	51	12	37	457
Food (N=555)	84	11	57	403
Clothing (N=554)	76	3	68	407
Family Needs (N=549)	67	11	37	434
Individual Counseling (N=550)	34	15	25	476
D.P.S.S. Problems (N=553)	26	20	23	484
Employment (N=555)	69	10	55	421
Housing Needs (N=550)	90	2	53	405
Legal Assistance (N=548)	53	3	27	465
Immigration (N=549)	76	5	48	420
ESL (N=553)	138	3	72	340
Adult Education (N=553)	104	3	41	405
Vocational Training (N=553)	45	2	26	480
Translation Services (N=553)	25	3	16	509

FINDINGS

Staff Training and Consultation

One of the three preventive mental health strategies of the MHP/IP was staff training and consultation. The literature has indicated that consultation is an important aspect of community mental health programs. In Head Start, consultation can be an effective means of providing training to teachers in promoting the emotional and social development of children. This section presents the findings for staff training and consultation of the 128 teaching staff and includes the following: 1) the Mental Health Classroom Observation/ Supervision Cycle; 2) Teacher Feedback of the Mental Health Classroom Observation Supervision Cycle; 3) the Mental Health Individual Child Observation/Action Plan; and 4) Staff Evaluation of Mental Health Services.

Mental Health Classroom Observation/Supervision Cycle. This cycle took place in each of the 64 classrooms in the first few months of the program. These cycles took an average of 5.5 hours per classroom totaling 352 hours. The mental health staff evaluated teacher performance and classroom environment and rated them on a scale of 1 to 5, 1 being unsatisfactory and 5 excellent. Table 5 shows the results of this evaluation.

According to the following chart, the areas in which the teachers exhibited the highest level of skills (ranking over 50%) in the good/ excellent category were: (1) providing an emotionally healthy environment; (2) demonstrating consistency and fairness; (3) interacting with the children; and 4) promoting positive child/child interaction. The areas in which the teachers exhibited the lowest level of skills (over 20%) in the unsatisfactory or needs improvement category were: (1) adult/adult interaction; (2) creating a level of positive stimulation in the classroom; (3) nurturing a child's self-esteem; and (4) behavior management. Based on the results of this evaluation, staff training and consultation were provided in the areas of need.

Teacher Feedback of the Mental Health Classroom Observation/Supervision Cycle. Following the Mental Health Classroom Observation/Supervision Cycle, the teachers completed the Teacher Feedback form on which they gave their comments on the cycle. Of LACA's 128 teaching staff, 75 (58%) responded. 67 (89%) stated that the cycle was helpful and 8 (11%) said that the cycle was not helpful.

Mental Health Individual Child Observation/Action Plan. When a referral was received, a mental health counselor did a classroom observation of the child. A Mental Health Individual Child/Action Plan was completed and provided the foundation for staff training to provide an emotionally supportive classroom environment. For program year 1984-85, the mental health component received 199 referrals and 168 of these reached the classroom observation stage. With a minimum of 3 hours of observation and consultation per referral, a total of 504 hours were provided. In addition, the mental health staff provided a minimum of 1½ hours per referral of additional training and consultation to the teaching staff totaling 300 hours. The total number of hours for staff training and consultation are 1,156 hours.

Table 5

Mental Health Observations of
Teacher Performance and Classroom Environment
N=64 Classrooms

TEACHER'S PERFORMANCE	Unsatisfactory or Needs Improvement	Satisfactory	Good/ Excellent
Behavior Management	20.3%	30.5%	49.14%
Child Support/reinforcement	18.63%	35.59%	45.75%
Interactions with children	8.47%	38.98%	52.53%
Communication Skills	16.94%	37.28%	45.75%
Nurturing child's self esteem	20.32%	32.2%	47.44%
Consistency/fairness	13.54%	32.2%	54.22%
Children's needs appropriately met by teachers	18.63%	38.98%	42.36%
CLASSROOM ENVIRONMENT			
Emotionally healthy/supportive	13.54%	30.5%	55.92%
Level of positive stimulation	22.02%	32.2%	45.75%
Positive Social Interactions child/child	15.24%	33.89%	50.83%
Positive Social Interactions child/adult	15.24%	37.38%	47.45%
Positive Social Interactions adult/adult	40.66%	18.64%	40.67%

Staff Evaluation of Mental Health Services. The mental health component, like all other components, was evaluated by the teaching staff in the areas of helpful services, services most valued, inappropriate services and lacking or insufficient services. Some of the helpful services from the mental health component were, according to teacher's responses: the providing of classroom management strategies, showing concern for children and families, responding quickly to referrals and involving parents in the problem solving process. Services most valued by teacher's included: the counselors' providing adequate time for talking with teachers about classroom problems, providing help for the special needs of children, and providing training to deal with emotional and behavioral problems. Inappropriate services included: lack of follow-up and inconvenient location for counseling. Finally, lacking of insufficient services included: lack of notice before site visits, need for increased communication between counselors and teachers, and lack of home visits.

Parent Education and Involvement

The purpose of the parent education and involvement activities of the MHP/IP was to support parents as the primary educators of their children and enhance the potential for parents to become involved in LACA's Head Start activities. Traditionally, the focus has been on parent involvement not parent education.

A comprehensive low-cost parent education program was designed by the author's for the MHP/IP which included parent education sessions, family nights, intensive parent education/staff training, and parent support groups. Though the MHP/IP under the mental health component made this initial plan for parent education with the approval of LACA's administration, when it came down to carrying out the actual program, the parent involvement component, with the support of the administration, designed and implemented their own plan for parent education which tended to revert back to the old model of focusing more on involvement rather than on education and involvement. The activities planned and organized by the Parent Involvement Component revolved around family nights and parent education sessions. The Parent Involvement component did not plan and implement these activities with the other components, and as a result, there was low turn-out.

Family Nights. This activity provided a forum for information, education and questions on parenting for family members as well as supervised play activities for children. It was an opportunity for parents to obtain further information to benefit them as the primary educators of their children.

Parent Education Sessions. These sessions were conducted by the parent educator (primary prevention). The sessions were done in clusters where parents from two or three sites met together at one location; the initial training provided one session for each parent cluster. Prior to the parent trainings, all LACA staff (supervisory and support) were given the same training. The objective of such training was to introduce all staff to the quality and content of the program. The expected outcome was broad parent participation in the training, supported by and encouraged by all staff (teachers, social workers, and parent involvement aides etc.)

Another problem held back the overall success of parent education and involvement activities. Parent educators, who were originally scheduled to begin work in November, 1984 were not hired until the end of January, 1985. As a result, training occurred late in the program year and only one session of parent education was provided which hampered the quality of outcome.

In-House Mental Health Treatment Services

This section presents findings for the in-house mental health treatment services of the MHP/IP. Included are: (1) frequency data on demographic information on families; (2) identification of treatment needs; (3) treatment characteristics; and (4) outcome evaluation of mental health treatment services. As previously stated, LACA enrolled 960 children for the program year 1984/85. The mental health component received 199 referrals representing 21% of LACA's population, and of these, 121 received treatment (representing 13% of the population).

Demographic data on families included the following information: of the families that received treatment, 59% were Mexican/Mexican American, 15% Caucasian, 7% other Hispanic, 5% Black, 3% other, and 11% mixed ethnic backgrounds. 49% of the families referred for mental health services were monolingual Spanish speaking, 32% were monolingual English, 17% were bilingual English/Spanish, and 2% other.

57% of the referred children lived with both biological parents, 26% lived with their biological mother, 9% lived with one biological parent and a significant other, and 8% lived with others (e.g., grandparents, foster parents, etc.). Of the 121 families that received treatment services, the average age for the mothers was 31 years of age and 33 years of age for the fathers. The average educational level for both parents was 8th grade.

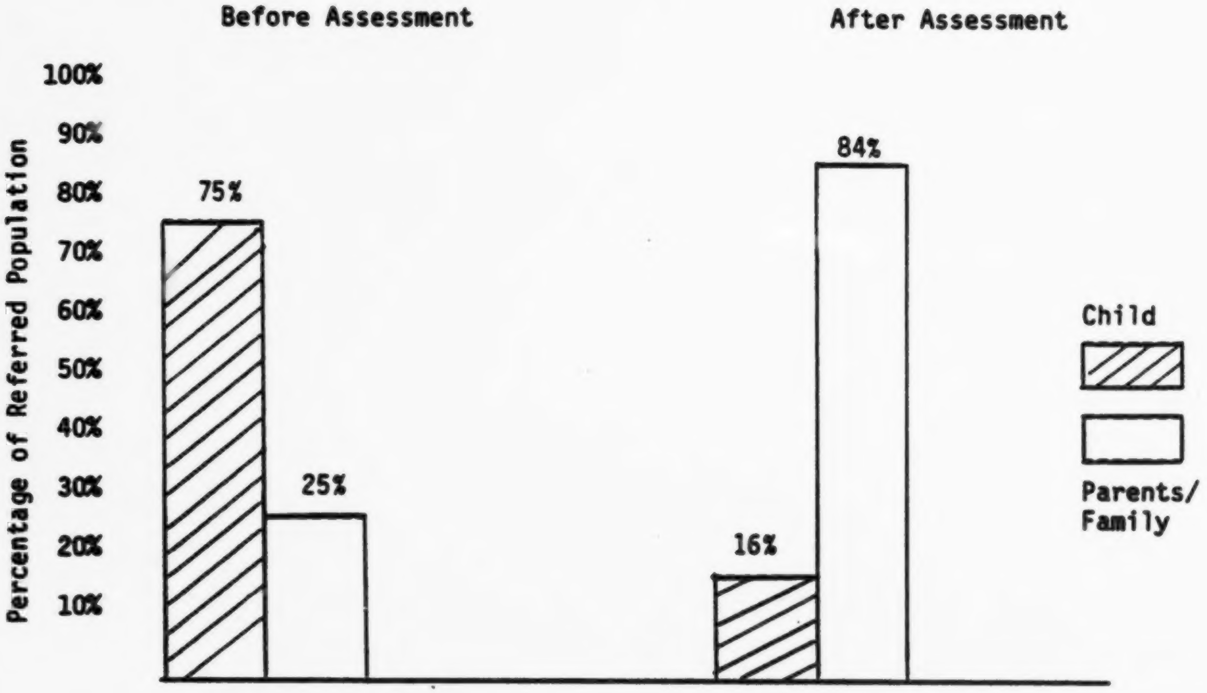
The length of treatment (from the date the case was assigned to the mental health counselor to the date the case was closed) ranged from 1 to 33 weeks, with a mean of 11 weeks. There were a total of 991 appointments made of which 627 or 64% resulted in sessions; 184 or 18% resulted in cancellations and 180 or 18% resulted in no shows. Of the total 627 sessions held, the number of sessions per case ranged from 0-32 sessions with a mean of 5 sessions per case.

Of the 199 referrals received by the mental health component, the original presenting problem (before the assessment of the case) showed the following breakdown: In 150 cases (75%) of the original presenting problems before assessment were on the child, and in 49 cases (25%), the original presenting problems before assessment was on the parents/family. After the assessment by the counselor, only 26 (16%) of the presenting problems after assessment remained on the child; but in 134 (84%) of the cases, the presenting problem after assessment shifted to the parents/family. 39 cases did not reach the stage of assessment (Table 6).

Table 7 shows the distribution of original presenting problems for both the child and the parents/family and how they were redistributed after assessment. Most of the original presenting problems were on the child, especially in the area of aggressive behavior, speech, and inappropriate developmental behavior. After assessment there was a dramatic shift to parent/family centered problems of which the most common problems were lack of parenting skills, individual unresolved issues, systemic dysfunctional communication, separation, divorce, and marital problems.

Table 6

Presenting Problem Before and After Assessment



Referred Children and Parents/Family

Table 7

Comparison of Original Presenting Problem and Problem After Assessment

BEFORE ASSESSMENT			AFTER ASSESSMENT: CHILD										PARENT/FAMILY													
		original presenting problem	separation anxiety	aggressive behavior	withdrawn behavior	non-responsive behavior	short attention span	depression	speech	developmental delay	age inappropriate behavior	other	marital problems	separation/divorce	lack of parenting skills	death	systemic dysfunctional communication	domestic violence	drugs	child abuse/physical	child abuse/sexual	individual unresolved issues	alcohol	other	N/A
CHILD	separation anxiety	15	•••	•										•	•		••	•				•••••			1
	aggressive behavior	32											••	••	••••••••••	•	••			•		•••••		•	8
	withdrawn behavior	13											•	••	••		••			•		•••••			-
	non-responsive behavior	13																				••••			2
	short attention span	5					•							•				•		•					1
	depression	1						•																	-
	speech	23			•				•••••	••••			•		•••		••		•			•	•		4
	developmental delay	13								••••					•		••••					•			3
	age inappropriate behavior	22								•			•••		•••••				•			••••			8
	other	14										••••	•		•		•••					•			4
PARENT/FAMILY	marital problems	5											•••	•										•	-
	separation/divorce	7												••••••								•			-
	lack of parenting skills	6													•••••							•			-
	death	5														•••••									-
	systemic dysfunctional communication	3													•		••								-
	domestic violence	3																•	•						2
	drugs	3													•		•								-
	child abuse/physical	2																		•	•				-
	child abuse/sexual	5						•													•	•		•	1
	individual unresolved issues	5																				••••			1
	other	4																							4
	Totals	199	3	1	1	0	1	2	5	9	0	4	11	13	37	6	18	3	3	4	2	33	1	3	39

Four types of therapy were provided adding to a total of 627 sessions. Of these sessions 161 (26%) were family therapy; 295 (47%) individual therapy; 102 (16%) conjoint therapy; and 69 (11%) play therapy.

Table 8 gives the breakdown of what occurred to mental health referrals. 19 children (9%) dropped from the school program before the referrals were received. 121 children/families (61%) received treatment. In 11 cases (5%) the presenting problem resolved itself before the initial contact.

In 41 (21%) of the cases parents either resisted or refused treatment because they denied the problem existed, had negative attitudes toward mental health, or, the refusal of one parent to participate in treatment usually discouraged the other parent and family members from coming to therapy. In 19 (9%) of the cases, children left the program before the referral was received. In 11 (5%) of the cases the presenting problem was resolved before the initial contact with mental health, while in 7 (4%) of the cases, the referral was inappropriate.

Table 8

Referred Status of Head Start Families Identified for Treatment

N = 199

Status of Referral	Numbers of Families Referred	
	#	%
Children dropped from school program before referral received	19	9%
Children/Families received treatment	121	61%
Presenting problem resolved before initial contact	11	5%
Parents refused/resistant to treatment	41	21%
Inappropriate referral (e.g., should have been referred to another component)	7	4%
Total	199	100%

The final review on all 199 referrals (see Table 9) received by the mental health component showed the following:

(1) Parents: In 121 cases (61%) parents reported that treatment was successful, 24 (12%) said treatment was not successful and in 52 cases (27%), the final review was not applicable.

(2) Teachers: In 115 cases (58%) teachers said that treatment was successful, in 22 cases (11%) treatment was not successful, and in 62 cases (31%) the final review was not applicable; and

(3) Counselors: In 118 cases (59%) the counselors reported that the treatment was successful, in 19 cases (10%) treatment was not successful, and in 62 cases (31%) the final review was not applicable.

The final review on the 121 cases that underwent treatment showed the following:

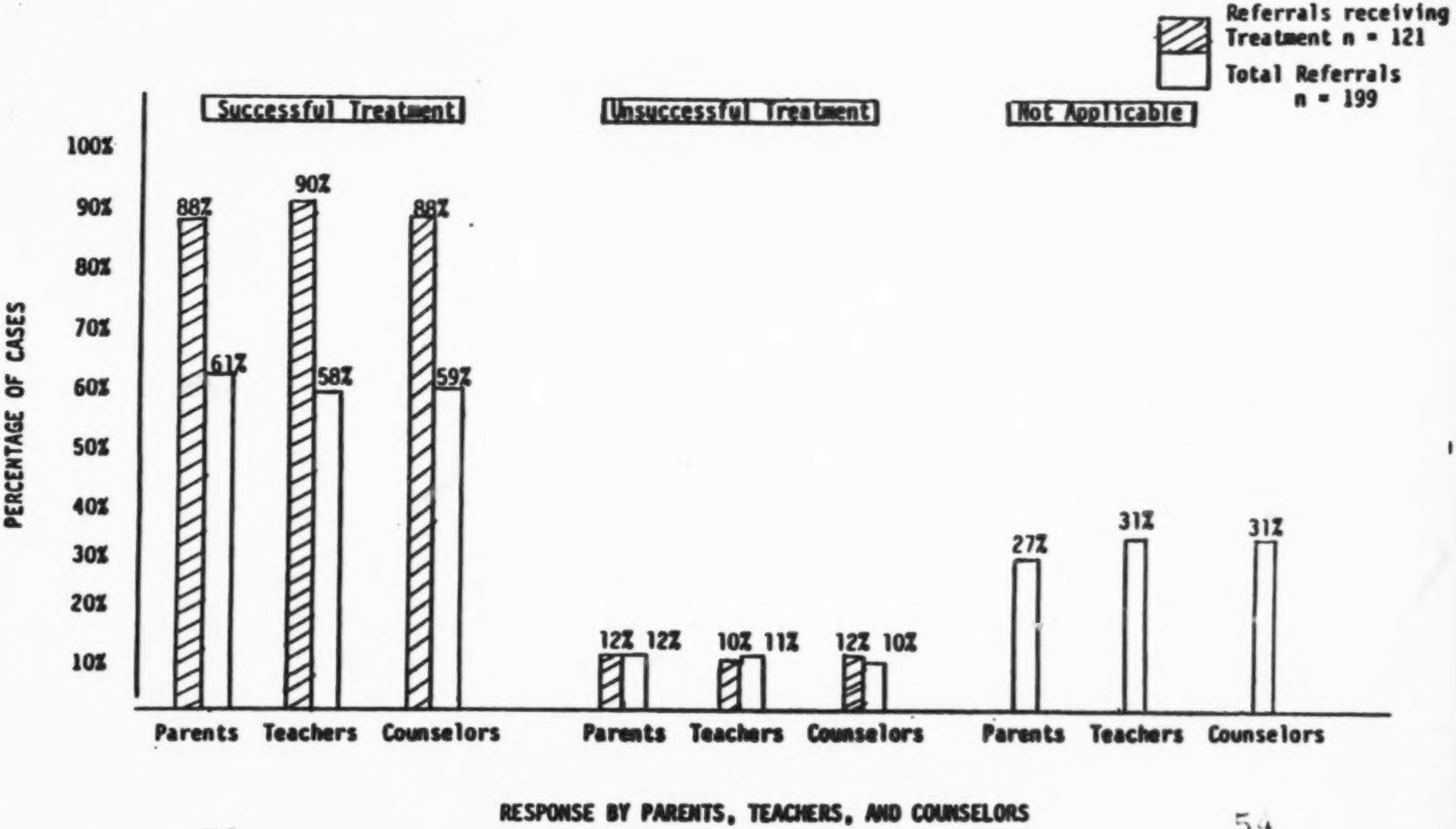
(1) Parents: In 107 cases (88%), parents reported that treatment was successful, and 14 (12%), reported treatment was not successful;

(2) Teachers: In 109 cases (90%), teachers reported that treatment was successful, and 12 (10%), treatment was not successful; and

(3) Counselors: In 107 cases (88%) counselors reported that treatment was successful and in 14 (12%), treatment was not successful.

Table 9

Final Review/Comparison of Treatment Outcomes based on Parents, Teachers, Counselors Evaluations



DISCUSSION AND RECOMMENDATIONS

Staff Training and Consultation

Mental Health Classroom Observation/Supervision Cycle. The Los Angeles Head Start Grantee recommends one hour of classroom observation per site followed by one hour of consultation. Through the Mental Health Classroom Observation/Supervision Cycle, the MHP/IP provided an average of 3½ hours of observation per class in all 64 classrooms followed by a 2 hour feedback with the teachers. Therefore, 5½ hours of consultation per class were provided adding to a total of 352 hours. If LACA were to follow the recommended hours for observation and consultation, (2 hours per site in 23 sites), a total of 46 hours of observation and consultation would have been provided. Furthermore, these 352 hours represent only one aspect of the staff training and consultation of the MHP/IP. Additional hours, as well as strategies for consultation and training of the teaching staff, were also provided adding to a total of 1,156 hours.

It was also evident teachers needed additional training in the area of social interaction so that they (as a teaching team) would function more effectively through the development of communication skills and increased classroom coordination. It is assumed that the interactions between the parents, teachers and assistants themselves would provide an effective role model for the children in regards to communication. In response to parent/teacher interaction, there is a need for initial detailed orientation of the parents on the importance and benefits of their participation in the classroom. A definite need exists for further training of teachers on the effective use of parent volunteers in the classroom.

The next highest area of difficulty was in relation to the level of positive stimulation provided to the children. 22% of the teaching staff were observed to have had problems in this area which included providing exciting and challenging activities for the children, encouraging the children's initiative and creativity, and the teachers' display of enthusiasm for their work. The mental health staff provided an important role in demonstrating techniques to the teaching staff regarding ways to increase the level of positive stimulation by pointing out the importance of encouraging children's creativity and sense of accomplishment, both of which can greatly increase a child's self-esteem. As children play a more active role in the classroom, and take age-appropriate responsibility, their social competence increases.

The Mental Health Classroom Observation/Supervision Cycle promoted early identification and intervention of children with problems. In comparing LACA's mental health referrals to other Head Start agencies in Los Angeles County it was found that the mean number of referrals from September 1 - December 31, 1984, was 8 referrals per agency representing 2% of the total Los Angeles County Head Start population. LACA had 111 referrals for that same time period, representing 11% of their population.

Is it that only 2% of the children in Los Angeles County Head Start are in need of mental health services, or, is it that children who are in dire need of mental health services are not getting referred because of little understanding and low priority for mental health services? The authors believe the latter is true and their belief is confirmed by the literature which shows 10-25% of the children in Head Start classrooms are thought to suffer from serious psychiatric and developmental disturbances. The significant difference is due to the fact the MHP/IP encouraged the early identification of children and families by conducting comprehensive classroom observations, training the teachers on identifying emotional problems and referring children to appropriate components.

Teacher Feedback for the Mental Health Classroom Observation/Supervision Cycle. Following the Mental Health Classroom Observation/Supervision Cycle, the teaching staff filled out the Teacher Feedback form on which they gave their comments on the cycle. 89% found the cycle to be helpful, while 11% found it not to be helpful.

According to teachers' responses, the vast majority were in favor of receiving training and valued the mental health staff's assistance, a fact observed throughout the program. In this study it was observed that hands-on training is an effective means of improving teaching skills. When training is presented from a positive standpoint and builds upon strengths, not deficits, then the teachers are responsive. Based upon these findings, it is important to acknowledge teachers' skills and expertise and to actually show them how these skills are essential in promoting an emotionally supportive environment in the classroom.

Mental Health Individual Child Observation/Action Plan. When a referral was received, a mental health counselor conducted a classroom observation of the child and worked with the teachers to develop an appropriate course of action for resolving the problems. By observing the referred child, emotional and behavioral strategies were implemented to meet the needs of the particular case. By working with the mental health counselor, the teacher had the opportunity to increase skills and develop his or her sense of competence as a teacher. Early identification and intervention took place with the potential to reduce existing problems that could have long-range damaging effects.

One of the most important aspects of this intervention was the provision of direct training to the teaching staff in handling the specific emotional and behavioral problems of a referred child. Possible causes and effects of manifested behaviors were explained and strategies for resolving these problems were given. In addition, the teaching staff acquired knowledge on the differences between the cause and the effect of behaviors and were able to recognize the need for treating the cause and not just the symptom. It is usually the symptom of a problem which is manifested in the classroom. As a result, the teaching staff was able to understand and support the approach of working with the entire family, not just the child in isolation.

The counselor made the teacher aware of the need for consistency between interventions at home and at school. The more involved the teacher felt in the team approach, the more effective he or she was in providing an emotionally supportive environment in the classroom. It has been the authors' observation that when direct training is provided to teachers which acknowledges their strengths, then the motivational level and trust in themselves as teachers will increase.

Staff Evaluation of Mental Health Services. The mental health component was evaluated by the teaching staff. This evaluation consisted of narrative responses and covered the following areas: 1) helpful services; 2) services most valued; 3) inappropriate services; and 4) lacking or insufficient services. The responses on the mental health component covered the areas of service delivery to teachers, parents and children. The purpose of these evaluations was to expose weaknesses and strengths of the component so as to provide optimal services to our children and families. These evaluations underscored the teachers' importance in the Head Start program and demonstrated to them that their recommendations were critical for improving the effectiveness of mental health service delivery.

Overall, the teaching staff felt that service delivery for children and families was effective. They stated on site direct training provided insight and strategies on how to minimize the incidences of behavioral problems, it facilitated their interactions with parents, and gave them an understanding of the importance of identifying and treating children and family's mental health needs.

Recommendations for Staff Training and Consultation

One recommendation for a successful staff training and consultation aspect of a Head Start program is the initial orientation (or possibly re-orientation) of the staff to the primary goal of Head Start - the promotion of social competence for the children and families served by the program. Research discloses a misconception with the goal of Head Start in promoting cognitive development alone in children. When conflicting opinions exist regarding the goal of a program (cognitive development vs. social competence), problems may arise in various aspects of programming, leading to ineffective service delivery. On the other hand, when the staff understands the goal of the program, they can unite as a team, provide comprehensive multi-disciplinary services to promote child and family development in the fullest sense, and thus recognize the importance of mental health service delivery. When the stigmas attached to mental health are directly addressed, the process of shifting the existing negative focus on mental health to a positive understanding of the need for mental health services begins. When this is followed by giving the staff a direct, positive experience of mental health service delivery, then their receptivity will be instrumental in the coordination and implementation of the comprehensive services provided.

The literature concurs with our findings which show there is a higher rate of success in response to training when there is a high level of interaction with the trainer. One way to foster a higher level of interaction between the teaching staff and trainer is to actively involve the staff in the process of determining the areas of training. Once the teaching staff and the trainer jointly agree on a plan for training and participation, success is more likely to occur.

The teaching staff also need to have an understanding of the importance of an emotionally supportive environment. When these skills are not present, the result is most likely to be an increase in the severity of a problem which could lead to long term pathology.

The authors' recommendation is for the National Head Start Bureau to recognize the importance of staff training and consultation in the area of mental health. Since Head Start serves a high risk population faced with severe problems, there is a critical need of having qualified, trained staff in the classroom who can understand, support and promote child and family development in the fullest sense, allowing for the accomplishment of the primary goal of Head Start - the promotion of social competence.

Parent Education and Involvement

The MHP/IP sought to increase parent education and involvement through a series of activities which would emphasize parenting skills, child development, and an understanding of normal child growth and development. Overall, it was felt these activities would further develop the social competence of parents, and thus remain in keeping with the overall objectives of the study. A comprehensive, low-cost parent education and involvement program was designed by the MHP/IP which had emphasized intensive parent education. It was unique because it viewed and shifted the focus from being solely parent involvement to parent education and involvement. Though the MHP/IP under the Mental Health component made this initial plan for parent education with the approval and support of LACA's administration, when it came down to carrying out the actual program, the Parent Involvement component solely designed and implemented their own plan for parent education which tended to revert back to the existing model which focuses more on involvement rather than education and involvement.

Along the way, plans for carrying out activities with parents seemed to have lost importance, so much so, that parent education and involvement resembled a mere supplemental activity. On another level, this problem seemed to be rooted to overall lack of clarity regarding what parent involvement, parent education, and parent participation actually mean on a policy level.

Recommendations for Parent Education and Involvement

The authors recommend the Head Start Bureau shift the current focus from parent involvement to parent education and involvement. Within the Parent Involvement Performance Standards, there is an existing focus on education. This has been a theoretical focus and to date has not been widely integrated into individual Head Start programs. It is recommended the Head Start Bureau select effective parent education models which can be implemented at the local level based on individual needs and/or cultural relevance. These models should emphasize the role of parents as the primary educators of their children. This can be carried out by promoting parents as partners with program staff in accomplishing the goal of Head Start, and in addition, helping prepare them to be trainers of other parents and thus serve as role models in the program.

These parent education models have the potential to promote the social competence of parents by enhancing their sense of self-esteem and thus creating leadership abilities which can, in turn, enhance their role as individuals, as parents, and as members of society.

In-House Mental Health Treatment Services

One of the reasons which led the authors to design and implement the MHP/IP was the clear evidence in Head Start of the need for comprehensive mental health service delivery. This need was verified not only through the authors' experience in the field of mental health and Head Start, but also through the literature. "Although Head Start programs are required to include a mental health component, no studies were located that evaluate the effect of mental health services (Synthesis Project, 1985:16)." Furthermore, the literature has consistently shown that 10% to 25% of Head Start children are in dire need of mental health services (Cohen et. al., 1979). Dr. Cynthia Barnes is the Executive Director of the Manhattan Children's Psychiatric Center (MCPC) which serves as the state children's psychiatric hospital for the borough of Manhattan in New York City. MCPC serves children and youth between the ages of 6-18 who have severe emotional and behavioral problems which require in-patient hospitalization or attendance in their day treatment program. Dr. Barnes has indicated that 80% of the children at MCPC had previously attended Head Start. Nevertheless, only 10% of these individuals had been identified while enrolled in Head Start. The remaining 90% were not identified, in most cases, until they reached the second grade and were generally incorrectly referred for speech and language problems, not the severe psychological problems they were having. For the most part, these problems were present when these children were enrolled in Head Start, yet without early identification and intervention the problems became so severe that in-patient hospitalization was required. Is it there have been no evaluation studies to assess the impact of mental health services on children, or is it there have been no comprehensive mental health services in Head Start to be evaluated? One way to confront the high percentage of children and families needing mental health services was to design a comprehensive program that could fill the gap left by Head Start policy.

During the 1984-85 school year, 199 children and families, representing 21% of LACA's population, were referred for mental health services. 72% of these referrals were made by teachers; this high percentage was due to their daily contact with children and families. 20% of the referrals were made by parents which seems to reflect that mental health orientations for parents was effective. The remaining 8% of the referrals were made by support staff.

Of the total number of referrals received by the component, 150 (75%) had the original presenting problem identified on the child and 49 (25%) had the original presenting problem on the parents/family. The original presenting problem refers to the reason for which the referral was initiated. It should be kept in mind that only the principal problem was calculated for purposes of these statistics. In many families, there were several presenting problems, per case. The teaching staff usually made the referral because an emotional and/or behavioral problem was exhibited by the child in the classroom. The predominant original presenting problems on the child were aggressive behavior, speech problems, age inappropriate behavior and separation anxiety. These findings are consistent with O'Regan, Reinherz, and Haworth (1980) who state the prevalent problem of preschool children is hostility and aggression. The predominant original presenting problems on the families were divorce and/or separation problems, lack of parenting skills, death, individual unresolved issues, sexual abuse, and marital problems. After the classroom observation, the parent/teacher conference, the preliminary and the screening sessions, the counselor was able to comprehensively assess the case and determine the cause of the problem.

After assessment of the cases, there was a dramatic shift from child-centered problems to family-centered ones. Parent/family problems constituted 84% of the problems after assessment as opposed to the 25% prior to assessment. Now, 16% of the problems were on the child, whereas before assessment, 75% of the problems were on the child (see table 6). 39 cases did not reach assessment. The initial assessments made on the child addressed problems evident in the classroom. However, when mental health counselors reassessed the child and the original presenting problem; it was discovered in most cases, that parent/family problems were the origin of the behaviors manifested in the classroom by the child (see table 7).

For example, in 31 out of the 32 referrals for aggressive behavior, the counselors discovered that after assessment, the aggressive behavior was the result of a parent/family problem. In 10 cases, it was due to lack of parenting skills; in 5 cases, individual unresolved issues of the primary caretaker; and in 4 cases, divorce and/or separation. In most cases, the cause of the problem was due to disruptive and/or dysfunctional family dynamics, and the whole family, not the child alone, was in need of mental health services. Age inappropriate behavior was also one of the most frequent reasons for referral for children (22 referrals). However, in all cases after assessment, it became evident the child's difficulty was due to lack of parenting skills, individual unresolved issues, or marital problems. Individual unresolved issues consisted of parents, foster parents, and/or the primary caretaker having to resolve their own individual problems which affected the child, and in most instances, the family. If the original presenting problem had alone been treated, then the child would have become the identified patient, and the origin of the problem (i.e., parent/family problem) would not have been resolved. These original presenting problems (e.g., aggressive, withdrawn and age inappropriate behavior, etc.) had the potential for becoming serious psychological and developmental disturbances if prevention, early identification and intervention had not occurred. For that reason, the MHP/IP emphasized the interconnectiveness of systems impacting upon the family and concentrated on treating the cause of behaviors.

In order to measure treatment success, a final review was completed on all cases. Three different sources were used in evaluating the success of treatment: the counselor, the teacher, and the parents. The counselor assessed whether treatment goals had been successful in resolving or reducing the problem. The teaching staff was asked to evaluate success based on the resolution of the child's problem in the classroom, while the parents were asked to evaluate the resolution of the problem within the context of the family.

There are several ways in which to evaluate the success of treatment such as psychological testing before and after treatment, changes in grades and academic performance, changes in behavior, and accomplishment of treatment goals. Because of the MHP/IP's orientation, it was decided success would be evaluated by determining if, in fact, treatment goals were accomplished, and if a significant change had taken place in the home and in the classroom.

The success of treatment was evaluated for two different groups. The first analysis was based on the total number of referrals received by the mental health component (199). The second analysis was completed on the 121 cases that actually received treatment services (preliminary and beyond). A comparison was made showing the significantly higher success rate for those families who received treatment.

Based on the sample of 199 cases, among the counselors, teachers, and parents there was a consistent assessment of success rates. Counselors reported 59%, teachers 58%, and parents, a 61% success rate. Lack of success was reported on 10% of the families by counselors, 11% by teachers, and 12% by parents. The remaining cases were not able to be evaluated because the child had dropped the program, the presenting problem was resolved before time of initial contact, or it was an inappropriate referral. Based on the sample of 121 cases that received treatment services among the counselors, teachers, and parents, there was also a consistent assessment of success rates. Counselors reported 88%, teachers 90% and parents, an 88% success rate. Lack of success was reported on 12% of the families by the counselors, 10% by the teachers and 12% by the parents. These figures, averaging about an 89% success rate, were relatively high, especially in light of the high risk population which was served, and the severity of family and child problems that existed. This high success rate demonstrates the effectiveness of in-house mental health treatment services (see table 9).

64% of the appointments scheduled resulted in sessions which is a very high follow through rate for treatment with a low income high risk population; only 18% of the appointments resulted in cancellations, and another 18% resulted in no shows. The number of sessions per case ranged from 0-32 sessions with a mean of 5 sessions per case. Leventhal and Weinberger had similar findings showing a 77 percent improvement rate for children in a brief family therapy averaging 5.2 sessions (in Children's Defense Fund, 1982).

It should also be noted that the relationship between who the child lived with, and whether treatment was successful was not significant. Whether the child lived with both biological parents, one biological parent and a significant other, or a single parent mother, there was the same possibility of success in treatment. And while single parent families may appear to experience stress and therefore greater potential for high risk, the MHP/IP found that regardless of family composition these groups can, through treatment services, resolve their problems.

There were a number of factors contributing to the high success rate of treatment services. First, the MHP/IP provided direct, comprehensive, in-house mental health services. The parent orientation held at the beginning of the year and the emphasis on a family's inherent strengths presented a safe and supportive atmosphere for exploring mental health issues through therapy. Second, the MHP/IP addressed the stigmas connected to mental health and how these stigmas had, in many instances, caused the community not to take advantage of mental health services. In addition, LACA's Head Start classrooms provided an entry point for assistance to high risk families. As parents became involved in the program, they were likely to gain confidence in the teachers, the organization and themselves. They learned about the available support services, health, social services, handicap, parent involvement, and mental health and how these services could benefit the entire family along with the enrolled Head Start child. They now had access to, and it appears they developed trust in a community provider of mental health services.

There has been a longstanding view in Head Start that children and families in need of mental health treatment services should be referred to outside community mental health agencies. However, research has shown this low income population rarely uses available community mental health services for reasons which include the stigmas attached to mental health, the belief the family should be able to manage their own affairs, the distrust of bureaucracy and, for the increasing number of ethnic minorities, the lack of bilingual and culturally sensitive counselors. Finally, over the last several years, there have been severe cuts in funding for mental health services. Most of the existing funds in mental health are used for adults, severe pathology, in-patient mental health hospitalization, and after-care facilities. The lowest priority in mental health funding has consistently been for children, families, ethnic groups and prevention.

A third factor related to these comprehensive mental health services was the team approach. The counselor and parents together reached a plan for treatment services, thus allowing the parents to feel like an integral part of the treatment process. The counselor coordinated services between the teacher and parents so a consistency in nurturing an emotionally supportive environment in the school and home existed. Parents consistently felt that treatment increased their sense of self-esteem, developed their communication skills, and assisted them in resolving personal, marital and familial problems, thus promoting their social competence. The MHP/IP's effect on the lives of these children and families may be the first step in the realization of change that can occur when a number of services are accepted and fully utilized.

The counseling staff contributed greatly to the success of treatment. Counselors were bilingual and had a knowledge of, and experience with, the different ethnic minorities which comprised LACA's high risk population. The counseling staff had extensive experience with preschool children and families, either were completing or had completed graduate school in psychology or related fields and were working on hours for their clinical licensing exam. Even though each counselor had a high case load (average 40 cases per counselor), there was sufficient time to effectively follow-through on each case. The counseling staff were highly committed and encouraged their clients to attend therapy and worked evenings so families would have every opportunity to attend therapy. For the most part, there was very little waiting time before the parents were seen for therapy. On the other hand, at many local community counseling agencies there is a one-three month waiting list. There was a deep sense of family love and commitment in the population served by LACA that was reflected in the results in therapy. The MHP/IP offered a unique situation because it not only identified children and families in need of mental health services but also offered in-house treatment. It was the concern of some Head Start administrators and staff that parents might react to these services as intrusive and, as a result, refuse or resist treatment. But, in fact, this was not the case, and the high success rate demonstrated the effectiveness of the MHP/IP's approach.

There is a need to shift the orientation of early intervention programs, in particular Head Start, which have historically focused on the child alone, to an orientation emphasizing service to the entire family (see HHS, 1980). The authors believe the child should not be seen in isolation but instead viewed as an integral part of the family structure whereby problems which affect the functioning of the family, affect the functioning of the child.

This shift from a child-centered approach to a family-centered approach was borne out by the findings where the original presenting problem, in 75% of the cases, reflected child problems and 25% of the cases were parent/family problems. After assessment, however, 16% of the cases, the problem remained child-centered and the remaining 84% reflected parent/family problems.

Through this assessment, the mental health counseling staff came to realize, problems of aggressive behavior in Head Start children, for example, originated with parent/family problems such as, lack of parenting skills, separation, and marital problems, etc. Basically, the cause of a problem was due to disruptive and/or dysfunctional family dynamics, not the child alone. It became obvious to the authors that treatment of the original presenting problems alone would have caused the child to become the identified patient and the origin of the problem would have gone unresolved. The use of an ecological model for treatment by the MHP/IP sought to bridge the gap between mental health treatment services and the interconnectiveness of systems that affect the family.

Human service delivery programs exemplify one example of this conflict. Historically these programs have viewed the individual in isolation from external issues which may impact on their lives. Attitudes emanating from human service bureaucracies have largely "blamed the victim" for their problems instead of seeing the interconnectiveness of systems which affect the family. The net effect of such views have generated the distrust and suspicion of clients towards human service delivery programs.

The ecological model addresses the origin of the problem and the interconnectiveness between the systems affecting the family, and places great emphasis on individual and family responsibility as a viable alternative to the position of blaming the victim. By addressing the causes of a problem, the ecological perspective allows for the improvement of the individual and family by promoting their social competence and enabling them to enhance their functioning in their lives.

Most importantly, through the ecological model, the MHP/IP designed a demonstration model to promote social competence in children and families. Inherent in this model was a shift from deficit models that place responsibility for problems on families alone, to a program structure emphasizing the existing strengths inherent within the child and family, regardless of language skills, economic or educational status. The counseling staff, by viewing parental relationships as the most critical in a child's life, acknowledged and gave the utmost respect to parents in their role as the primary educators of their children. This orientation proved its success by the results in therapy.

The MHP/IP's ecological approach, has the potential to enhance Head Start as a successful early intervention, family-centered program, allowing Head Start to reach its primary goal for both the child and the family--the promotion of social competence.

Recommendations For Mental Health Treatment Services

National Head Start Bureau. A primary recommendation of the MHP/IP is for the Head Start Bureau to recognize the importance of mental health as a critical component in accomplishing the primary goal of Head Start - the promotion of social competence. This can be accomplished by recognizing the importance and need for comprehensive mental health services to the Head Start population, as well as establishing mental health as a priority in the areas of funding and training. This needs to be an all-out united effort to insure a national change in Head Start mental health services. The MHP/IP recommends that a national mental health needs assessment be conducted in Head Start for the purpose of gathering substantial data which can be used to access the needs of Head Start children and families and the levels of mental health services that are presently being delivered. Such an assessment can be useful in formulating a national plan for upgrading Head Start mental health services as well as impacting on the formulation and implementation of Head Start policy.

The Head Start Bureau can make mental health a training priority under Training and Technical Assistance (T&TA). This training should address the following points:

1) The need to shift from the existing cognitive orientation in Head Start to the original goal of social competence;

2) The importance of mental health in the accomplishment of this goal;

3) The relevance of the shift from a child-centered program to a family-centered program;

4) The emphasis on parents as the primary educators of their children;

5) The stigmas attached to mental health and ways to counteract them;

6) The relevance of switching the focus in mental health from pathology to prevention, health and wellness;

7) The importance of prevention, early identification and intervention of child and family related dysfunctions which have the potential of producing long-range damaging effects;

8) The multi-disciplinary team approach to the delivery of services to Head Start families; and

9) Working models for implementing mental health service delivery in various settings (i.e., urban, rural, etc.).

Since this Training and Technical Assistance needs to be an all-out national effort in order to become successful, the authors are recommending training be provided to the following people: (1) Head Start Bureau Administrative staff, (2) Head Start Regional Administrative staff, (3) Grantee Administrative staff, (4) Head Start directors and component supervisors staff, and (5) Head Start teaching and component support staff. The National Head Start Bureau has begun to recognize the need for mental health but, recognition, discretionary grants, and dissemination alone will be meaningless without the full support of national policy in the areas of planning, programming and funding.

Comprehensive Mental Health Services Need to be Provided by Head Start. The authors are recommending that Head Start agencies implement comprehensive, in-house, direct mental health service delivery programs which provide for prevention, early identification and intervention of problems for children and families. The MHP/IP provides such a model which can be replicated and adapted in various urban and rural settings to meet the individual needs of Head Start agencies across the nation. It is further recommended that Head Start urban programs hire a full time, licensed mental health professional, whose sole responsibility is the supervision of the mental health component. Historically, a paraprofessional mental health coordinator supervises two or more components (including mental health), then contracts with a consultant who provides the services.

Depending upon the size of the agency, and its budget capabilities, additional professional and/or para-professional staff can be hired. The MHP/IP employed 6 staff: 1 licensed mental health specialist and 5 full-time counselors. Six staff for 960 children represent a ratio of 1:160. The budget was $100.00 per child for the year 1984/85.

The MHP/IP recommends that a national strategy for the utilization of graduate students be designed and implemented. Head Start can set up internship programs with volunteer or stipend graduate interns in the fields of psychology, counseling, early childhood education, social work, and other related fields. Under the supervision of licensed Mental Health Specialists, all mental health staff, including interns, can undergo comprehensive training to provide in-house, direct mental health services to the children, families, and teachers. They should have a commitment to working with a high risk population, cultural sensitivity for the ethnic minority served, and, when needed, bilingual capabilities. Head Start can set up official linkages with national psychological associations such as the American Psychological Association, the National Association of Social Workers, etc. for the utilization of these students.

Head Start can then become an established, recognized, ecologically oriented training ground for future therapists and child development experts specializing in the fields of children, families, high risk populations, cross-cultural counseling, prevention, health and wellness. This ecologically oriented program has far reaching implications in the area of psychology, switching the existing focus from pathology and a deficit model, to a focus on prevention, health, wellness, social competence, and family strengths.

In a rural setting, different Head Start centers could pool their resources for mental health services, and jointly hire a licensed mental health specialist who could recruit, provide a plan for training and supervise a staff of para-professionals and stipend graduate interns. The great distance between many rural Head Start centers would also have to be taken into consideration in working out a plan.

If certain Head Start agencies decided not to develop a plan to provide in-house direct mental health services, then these agencies should establish formal linkages with existing mental health community agencies which would provide for the early identification and intervention in problems affecting the Head Start child and family. The mental health community agencies should have staff who are able to handle the problems associated with high risk. The authors' have observed mental health agencies generally do not provide for prevention, early identification, and intervention of problems in children and families due to large case loads, long waiting lists, and low priority in funding for services for children, families, minorities and non English speaking populations. Therefore, if these linkages are to occur, the provision of comprehensive mental health services to the Head Start population should be incorporated in the overall planning of services of existing mental health agencies. It is recommended that under the Mental Health Block Grants to states, Head Start be incorporated into the regular budget for programming and funding.

Head Start presently serves approximately 400,000 children a year. Each family has an average of 5 people per household. Head Start has the potential to provide services to approximately 2 million people annually. A model such as the MHP/IP, which provides comprehensive mental health services in the areas of prevention, early identification and intervention, has the same potential, over a generation, to affect change with 40 million people. At present, there is no other model that has the potential to strengthen the lives of children and families in this country in this way.

Shifting the Focus in Head Start from Promoting Cognitive Development to Promoting Social Competence. To date, Head Start has had its primary focus on a cognitive oriented education with an emphasis on the components serving the education component. The MHP/IP proposes a model where all the components work cooperatively and interdependently to serve the Head Start child and family. In this regard, the MHP/IP is proposing a shift from a program which has primarily emphasized cognitive development, where all the components serve the education component, to a program which focuses on the promotion of social competence. All the components including the education component, would serve the Head Start child and family.

In the existing model all the service components serve the education component which primarily focuses on the cognitive development of the child (child-centered program). The MHP/IP recommends a shift to the proposed model which has all the components of Head Start, including the education component, functioning interdependently within the framework of a multidisciplinary team approach aimed at accomplishing Head Start's ultimate goal - the promotion of social competence in children and families (family-centered program) (see diagram).

An Ecological Model for Mental Health Service Delivery. The MHP/IP is recommending the use of an ecological model with its broader focus over the less effective deficit models. The child is not a cognitive entity alone. He or she must be viewed from an ecological perspective. The child has a physical body, a social and emotional essence, and must be viewed as an integral being who interdependently relates to his family, community and society. The authors are recommending the Head Start child and family be viewed from a holistic systems orientation; a multi-vectored ecological approach to treatment, where the child and the family are seen as interacting within a number of systems - biological, psychological, social and environmental. The MHP/IP suggests that for educational and human service delivery on a national level, the child no longer be viewed in isolation from the family. A shift needs to occur from a child-centered program to a family-centered one where the family is viewed as an integral unit. A problem that affects one, affects the whole.

The ecological model addressed the origin of the problem and the interconnectiveness between the systems affecting the family. Therefore, when a child is exhibiting problem behavior in the classroom, (e.g., aggression, withdrawal, etc.) the origin or cause of the problem, (e.g., family conflict) is treated. Many in Head Start and in human service delivery systems have tended to focus on the effect of the problem rather than the cause and thus perpetuating the belief the child and family are the "victims of society". For instance, when a child's basic needs are not met, (i.e., food and shelter), Head Start programs tend to give the child a "head start" in the classroom and help to resolve the basic need for food and shelter instead of looking at the causes which led the family to be dysfunctional. Poverty, discrimination, unemployment and other social ills of the times seriously impact on the healthy functioning of a family. However, the fact some families are faced with these problems and are still able to successfully function, leads one to believe that factors other than environmental and social ones also contribute to family functioning. The potential to overcome social ills begins when one becomes aware of the interconnectedness between the internal (persona) and external (societal) factors, then one can begin to create attitudinal change which can then lead to transformation on individual and societal levels.

The MHP/IP promotes individual responsibility, and proposes alternatives for problem resolution instead of blaming the victim and/or blaming society. In order to impact on the total family system, an emphasis should be placed on treating the entire family, not just the child in isolation who has become the identified patient. The child's behavior is seen as one of the effects of a family's dynamics. Human service delivery systems need to treat the cause of a problem, not just the effect, if our goal is to make long term significant changes in children and families. The families were assisted in looking at both internal and external issues not in terms of deficits, but rather as areas that could be changed if the individual so desired. The MHP/IP is recommending the ecological approach become the state of the art in programs aimed at strengthening families abilities to improve their lives and successfully function in society.

Implementation of a Team Approach to Mental Health Service Delivery. A mental health service delivery plan needs to emphasize a team approach where the parent, teacher, and mental health counselor work together in promoting child and family development in the fullest sense. When there is coordination between parents, teachers, and counselors, a consistency will result between the home and school environment. Teachers need to be trained to recognize the criticalness of the parents' role and how to effectively interact with parents. Parents should be viewed as the primary educators of their children and need to play a critical role with counseling staff in jointly deciding the course of treatment.

Impacting Change in Human Services and the Educational System. The MHP/IP can serve as a model to affect change in human services, and the educational system. It proposes that programs in human services move away from an orientation on the deficit model, to a focus on a competency model building on the child and family's inherent strengths. Programs need to switch their concentration from pathology and treatment to a focus on prevention, health and wellness. For human services and the educational system the child can no longer be viewed in isolation from his or her family. Families need to be treated as an integral unit.

Much of the work done through the MHP/IP, involved primary and secondary prevention. This preventive focus contrasts with the typical tertiary remediation interventions which traditional mental health programs focus on. Many of the problems seen at LACA were at early stages of development. Early intervention had the potential to resolve these problems. As an example, in many cases, the potential for child abuse was present. However, because of the early intervention which focused on parenting skills, reducing stress and improving family communication, these potential problems were diverted. If some of the money for the treatment of child abuse were redirected to the prevention of this problem through such programs as the MHP/IP, it is assumed there would be a substantial reduction in severe problems such as child abuse.

For the educational system it is recommended that all children be observed during the first two years of elementary school by a mental health specialist so prevention and early identification of psychological and developmental disturbances could occur. If a problem were observed, a conference would be scheduled with the parent, teacher and mental health specialist. At this time a plan for intervention would be recommended. Either the child and family could be seen by the school psychologist or graduate psychology/counseling interns, or a referral to an outside agency could be made. During the first two years of school, all parents could be given the opportunity to attend parent education classes provided by the educational system. The focus would be on viewing parents as the primary educators of their children and increasing their understanding and skills in their critical parental role.

For these changes to occur in the educational system, the public must first become aware of the importance of mental health and its impact on a child's educational performance, his or her functioning within the family system, and in society at large. This awareness needs to be followed by legislative action and budget allocations. Mental health programs in the educational system and programs such as the MHP/IP, in conjunction with longitudinal studies, could be an important step in reducing mental illness, juvenile delinquency, school drop-outs, anti-social behavior, alcohol and drug abuse. These programs have the potential for strengthening the children and families of this country. The education system is in dire need to switch its current focus from the cognitive approach to a focus on social competence. The child would be viewed as a whole person, emphasizing his or her interaction with oneself, the family, and society. The ecological orientation promotes social competence which nurtures an individual's sense of self-esteem, individual responsibility, personal integrity, interdependence, and one's effectiveness in dealing with his or her environment, and a concern for the whole.

Cost Effectiveness

In projecting cost-effectiveness for the MHP/IP it was assumed that early intervention through the provision of mental health services were similar to those secured through early education - the children would become socially competent and able to achieve within the regular educational system as they enter and progress through public school. Several studies can be cited which address the issue of cost-effectiveness for early intervention. Wood (1980) reviewed the cost of providing special education intervention at various age levels. The data collected demonstrated that the cost per child to age 18 decreases as the age of intervention decreases (e.g., intervention at age two = $37,600; intervention at age six = $56,816, intervention at age six with no eventual movement to regular education = $53,340). Thus, assuming a $2,304 cost each year in which a student is not involved in an intervention program between the ages of two and six, the cost of education per child to age 18 receiving intervention at age three, would be $39,904. This is a savings of $6,912 per child if contrasted to intervention at age six. Additionally, assuming early intervention leads to placement within the regular education setting, the average per child savings would be $13,436. Other evidences for cost effectiveness of early intervention programs can be found in the literature (Weber, 1978). Further, a cost benefit analysis would give additional consideration to savings which resulted from taxes recovered from earnings, income maintenance reductions, and institutional avoidance (special schools, penal, as well as mental health institutions). For example, mental health institutionalizations average $50,000 per year. The budget for the MHP/IP was $125,000. $96,000 of this amount covered direct mental health services for 960 children. Therefore, the cost was $100.00 per child per year. Head Start presently serves approximately 400,000 children. If mental health services were provided at a cost of $100.00 per child, per year it would cost $40 million per year. Head Start's present budget is $1 billion per year and the $40 million per year that is being proposed to be used for mental health represents 4% of the total budget.

Social Competence and the Ecological Approach to the Head Start Family

Throughout this analysis, the ecological approach to the understanding and assessment of children and families has been emphasized. It is critical that the reader understand the process of analysis and the implementation of this approach. For example, it is important that intervention strategies and evaluation methods be merged into this ecological approach. The way a problem is assessed will determine how a problem becomes defined. The levels of assessment may be determined from the individual, group, organizational, and community level. If the problem is defined as resting with the individual then the intervention strategies as well become focused towards the individual. If the problem is identified as a group or organizational concern, then strategies of intervention will be directed at group or systems change.

Although Head Start is based, in theory, on this paradigm, the focus throughout the program's development has been directed primarily at the individual child level. That is, the primary focus has been directed at the improvement of cognitive abilities rather than the observed competence of the child in the classroom. Cognitive abilities of the child had, until this effort, largely become the determining factor of competence. Families have been an integral part of the Head Start philosophy and the emphasis of components, such as Parent Involvement and Social Service, have attempted to respond on a broader systems level to this orientation.

Traditionally, however, the components have worked with parents alone in this service delivery. The MHP/IP is now recommending that all Head Start components reorient their delivery system to serve Head Start children, siblings and parents as an integral family unit. Specifically, whether a particular component works primarily with the child (Health and Education), the parents (Parent Involvement and Social Service), or with the family (Mental Health); it is time to shift attitudes where the components are aware of and serve children and parents as a family unit.

From assessment to treatment intervention to outcome evaluation, the ecological dimensions which address biological, psychological, social and environmental factors, influence the potential for growth and prevention of long-range problems. All of these factors have their effect on the abilities of any child and family for a healthy and productive life.

The concept of social competence presented in this study is directly linked to the concept of mental health prevention and intervention. The promotion of positive mental health concepts and the prevention of problems through early identification indicate, as a result of the findings in this project, that social intervention with young children and families is a strategy whose time has come.

The provision of comprehensive mental health services is critical in accomplishing the primary goal of Head Start, the promotion of social competence for children and families. The full support of national policy in the areas of planning, programming and funding for mental health in Head Start with an emphasis on prevention, early identification and intervention is vital. More action is needed if mental health services are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbances through early identification and intervention. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

FINAL REPORT

Introduction

This report will present, analyze, and discuss the results of a mental health demonstration and research project entitled, "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention" (referred to as the MHP/IP [Mental Health Prevention/Intervention Project] throughout the remainder of this report). The project was submitted to and funded by the U.S. Department of Health and Human Services/Coordinated Discretionary Funds Program for fiscal year 1984/1985. The Latin American Civic Association (LACA) was the recipient of this 14 month grant which covered the period from August 1984 to September 1985. LACA, a non-profit organization, is one of the largest Head Start delegate agencies in the state of California. With a staff of 192 employees, it serves 960 children and families at 23 sites and 64 classrooms.

The MHP/IP assessed the effectiveness and proposed a model of mental health service delivery to a high risk Head Start population. Three preventive mental health interventions were tested: 1) staff training and consultation, 2) parent education and involvement, and 3) in-house mental health treatment services, including short-term psychotherapy.

The first intervention, staff training and consultation, was designed as a primary prevention strategy to provide services to teaching and service component staff on the implementation of mental health skills to increase their job effectiveness. The second intervention, parent education and involvement was also designed as a primary prevention strategy to provide training and needed skills to support parents as the primary educators of their children, as well as to empower parents to participate in Head Start activities, and in the lives of their children and families. The third intervention, in-house mental health treatment services, which included short-term psychotherapy, provided secondary prevention, early identification, and intervention of children and families with problems, as well as encouraging prompt referral to mental health and/or appropriate components. The counseling staff provided short-term psychotherapy which offered the opportunity to reduce social or psychological dysfunctions which had the potential to produce long-range damaging effects.

The research aspect of this study was carried out through the utilization of a series of instruments which enabled reseachers to collect three types of data. The first type of data collected was through the implementation of a needs assessment designed to provide information regarding the needs, social history, and special circumstances impacting upon the family and child. Information regarding problems of high risk and utilization of human services provided an understanding of the system about which families are aware. The needs assessment was administered to 960 families participating in LACA's Head Start program. The final returns yielded a sample population of 845 completed interviews.

A follow-up assessment, implemented with a sample of 220 families, provided baseline comparisons with the needs assessment population. More importantly, this document provided data on any changes encountered by the family during the year in Head Start. A second type of data was collected through the Family Social Competence Survey which identified those factors which would serve to enhance the ability for early identification and early intervention with Head Start children and families. By focusing on the strengths of families, this survey underscored the need for human service professionals to work with families as partners. A third type of data was collected on 199 children and families who were referred to the mental health component. The documents provided data on demographics, treatment and outcome evaluations on individual cases. This data was gathered from counselors, teachers and parents.

Another important aspect of the MHP/IP was the utilization of the ecological model with its broader focus over the less effective deficit models. In the MHP/IP the child and family were viewed from a holistic systems orientation. A multi-vectored ecological model of treatment was used combining biological, psychological, social and environmental factors. In essence, the MHP/IP focused on working with family strengths not deficits; that is, parents were seen as partners with program staff working together to enhance child and family development.

The ecological model addressed the whole person: the internal and external factors that comprise an orientation to the interrelatedness of one's self and one's environment. Deficit models, on the other hand, tend to assume low-income families are poor because of a set of social and psychological conditions which keep them at these levels. Although these models gained influence during the War on Poverty, critics have established that deficit models, "blame the victim" for their problems and do not address the inegalitarian structures of society which helped to foster these conditions. Instead, the MHP/IP proposed to view a person from a multi-vectored ecological perspective.

The primary goal of Head Start is the promotion of social competence. Approximately 80% of the Head Start population are enrolled in center-based programs with a primary focus on a cognitive oriented education with an emphasis on the components serving the education component. The MHP/IP project proposed a shift from a program which has primarily emphasized cognitive development - where all the components served the education component - to a program which focused on the promotion of social competence in Head Start children and families, and where all the components, including the education component, serve the Head Start child and family. The child is not a cognitive entity alone. From an ecological perspective, the child has a physical body, a social and emotional essence and, is viewed as an integral being who interdependently relates to his family, community and society.

To date, there have been few research studies undertaken to show the effects of mental health service delivery in Head Start programs. A report, Head Start in the 80's (HHS, 1980) recommended a shift from a child-centered to a family-centered program. The effectiveness of our proposed model, which is in keeping with this recommended shift, portends that for education and human service delivery on a national level, the child no longer be viewed in isolation from the family. Rather, the family should be considered as an integrated unit.

The potential for prevention and treatment services in the area of mental health for Head Start children and families has been recognized as critical. The theory of prevention holds that through early identification and intervention the high incidence of severe problems and the potential for long-range damaging effects will be reduced. And yet, no model for prevention, intervention, and treatment services has been demonstrated as an effective strategy for mental health service delivery. The MHP/IP proposes a model for prevention, early identification, and intervention which could become the state-of-art for mental health in Head Start as well as provide a model for national change in the educational system.

This report comprises three sections. In Section 1, The Research Focus, Chapter 1 addresses the importance of going beyond the use of deficit models and recommends a shift to an ecological model. The history of the War on Poverty and the culture of poverty orientation, as well as the origin of Head Start are also discussed. Chapters 2 and 3 address the evolution of mental health theory and practice and the concept of social competence. The purpose of these chapters is to review the literature and thus set the foundation for the focus of the MHP/IP. This theoretical overview sets the stage for chapters 4 and 5 which outline the research strategy and design of the study. Chapters 6 and 7 present the findings based on the needs assessment and follow-up assessment as well as a social competence profile of Head Start families.

In Section 2, The Findings, Chapter 8 presents staff consultation findings, Chapter 9 presents the findings for parent education and involvement, and Chapter 10 presents the findings for in-house mental health treatment services, including short-term psychotherapy.

Section 3 discusses these findings and presents recommendations and implications for social policy. Chapter 11 addresses staff training and consultation; Chapter 12, parent education and involvement; Chapter 13, in-house mental health treatment services; and Chapter 14, social competence and the ecological approach to the child.

SECTION I

THE RESEARCH FOCUS

Chapter 1

BEYOND THE CULTURE OF POVERTY

Overview

The focus of this chapter is to present an overview of the War on Poverty and how policy development within anti-poverty legislation affected Head Start. Moreover, this chapter critiques the inherent weaknesses of deficit models and suggests that the ecological model of human development (Bronfenbrenner, 1979b) is more comprehensive in explaining the realization of society's human potential. It is only natural then the chapter begin with a discussion of the War on Poverty: its origins, purpose, and relationship to preschool education. Next, the objectives of Head Start are reviewed in light of how the program proposed to give poor children an opportunity to succeed in school. The debate between social competence - how one copes with one's environment, internally and externally, - and cognitive orientations - how one learns - are also discussed. Lastly, the chapter ends with a critique of deficit models particularly as they relate to social intervention programs. The aim of this section is to propose a step which takes policy beyond deficit models and instead, attempts to elaborate a more humanistic approach to policy based on an ecological orientation of human development.

The War on Poverty

The roots of the War on Poverty generally began with the policies of the Kennedy Administration. While campaigning in West Virginia, Kennedy was taken aback by the poverty he saw. He became even more concerned when, in 1962, he read Michael Harrington's book, The Other America, which basically concluded that the circle of poverty, originally addressed by Myrdal (1944), was fast becoming a culture of poverty. Kennedy suddenly took sharp focus on the issue of poverty and outlined a program to combat it.

Another influence was Kennedy's Committee on Juvenile Delinquency. Lloyd Ohlins, a member of the committee, wrote that delinquency arises from unequal opportunity structures in the education system and labor market. As the doors of opportunity close, it was surmised youth turned to delinquent behavior. The cure was to attack the social system which bred this problem and not necessarily treat individuals as if their deviancy was merely an internal problem. In sum, Ohlins felt that institutional reform was the answer (Friedman, 1977).

When the Johnson Administration assumed the reins of the government, the ideas shaped during the Kennedy Administration were sharpened and implemented as the War on Poverty. This assault on poverty became the center of the Great Society program which Johnson proclaimed would change the face of America (Friedman, 1977). Included was a progressive civil rights bill, manpower programs, innovative educational priorities, the creation of Medicare and Medicaid for the elderly; all of which were designed to ameliorate the conditions of poverty which had been manifested largely among diverse ethnic groups.

There was an air of excitement knowing steps were being taken to eradicate poverty in the United States which would thus help to realize the principles on which the country was founded. For example, Wolfbein (1967) wrote about the early years of policy development leading to the creation of the War on Poverty which addressed the optimism of the times and the optimism that became the foundation for federal anti-poverty programs in general: "The basic philosophy of the War on Poverty, for example, rests on the necessity for intervening with appropriate programs to interrupt and, hopefully, to break up the cycle of the generation-to-generation poverty which exists among significant sectors of the population (p. 14)."

The War on Poverty reflected a specific philosophy which assumed poverty in the United States could be eliminated. A report by the Council of Economic Advisors published in 1964 and titled, "The Problem of Poverty in America", gave impetus to this view of poverty: that an interrelated set of factors all mutually independent contributed to poverty - a poor education, restricted employment opportunities causing a lower standard of living and so on, generation after generation. Thus by attacking anyone of these factors poverty might be reduced. The main emphasis of the report was the elimination of poverty through education (Spring, 1976).

Education and Poverty

To understand the strategies which evolved from the War on Poverty, it is necessary to examine the relationship between education and poverty as seen by policymakers and how this relationship was translated into actual program goals. According to Spring (1976), the major theoretical arguments which supported the War on Poverty assumed an integrated set of social and psychological conditions existed among the poor which could be directly attacked by comprehensive government programs.

The early influences which helped give direction to intervention programs were based, at least in part, on Myrdal's (1944), An American Dilemma, and Harrington's (1962), The Other America. The Myrdal model suggested a cycle of poverty revolving around a set of psychological characteristics which helped to maintain this condition. Harrington took the position the cycle was quickly becoming a culture of poverty and due to the increased isolation of the poor from the rest of society, America would eventually be divided into two parts. His solution to poverty was a total assault on those factors related to the culture of poverty: housing, employment, education, and medical care.

These notions also reflected a particular view of why one was poor. Levin (1972) for example, wrote that the poor were identified within the parameters of two groups: those outside the labor force and those with at least one potential labor force participant. There are two possible explanations why those who can work are poor: 1) individuals are not willing to work or that when they do work, renumeration is small; and 2) there is inadequate employment demand for workers to obtain productive employment, and there is a particularly low demand for workers from those groups whose incidence of poverty is highest, such as minority individuals, youth, women, rural and inner-city residents. The government chose to invest in human capital by "reducing their inadequacies (p. 125)." However, the view of low job demand was not considered.

As Levin (1972) further explains:

> The existence of poverty among families with potential workers is due primarily to the low productivity of such workers; in turn, low productivity is attributable to low skills and initiative that result from the cultural and other disadvantages associated with these groups; finally, government investments in education and in other areas of human capital would increase the opportunities and income of workers from such families by raising their productivities and resultant incomes. It was thought that by increasing the job-related skills of the poor, education and training would provide an usually promising vehicle for raising productivity and alleviating poverty (p. 127).

The basis for strategies then were based on the culture of poverty suggested by Harrington (1962). One implication of this view was that parents passed on these negative characteristics to their children thus setting up the vicious cycle which continues generation to generation. A second implication assumed those characteristics were so pervasive that they had to be countered while the child was still young.

The strategies developed by the War on Poverty then, were designed to remove the maladies inherent in poverty which prevented the poor from participating fully in society. On one level, improving cognitive skills in young children was a focus of educational programs, while training for specific occupations or providing financial assistance to postsecondary education constituted programs which went beyond the secondary level. There were thus three basic strategies for eliminating poverty: basic cognitive skills, increased educational attainments, and training for specific job skills (Levin, 1972:151). Between the years 1965 - 1974, some 30 federal educational and training programs were established to combat the conditions of poverty faced by many groups. These programs can be classified according to age and include: preschool, elementary-secondary, young adults, higher education, and adult programs. In the preschool category, Project Head Start was established to provide readiness skills for primary schooling as well as a host of other services.

The Objectives of Head Start

One of the many policies developed as a result of the War on Poverty was the Economic Opportunity Act (EOA) of 1964. The elements of this legislation rested on the concept of community action, a desire to develop an opportunity structure for youth and, like other anti-poverty programs, was theoretically linked to the culture of poverty perspective (Spring, 1976). The development of community action programs relied on local initiative and leadership. It was rationalized that by giving local individuals the opportunity to be involved in such programs, skills could be learned which would help them break from the culture of poverty. EOA's first director, Sargent Shriver, was quoted as saying, "we want to give young people a chance to escape from the cycle of poverty and to break out of the ruthless pattern of poor housing, poor homes, and poor education." There were also many projects designed by Title II community-action program activities which were national in scope and were contracted out through local agencies. By 1968, these projects included Head Start, Family Planning, Upward Bound, Comprehensive Health Services, Senior Opportunity Services, and Legal Services. While all of these programs were important and have served countless numbers of people, Head Start has become the most popular of the national community-action programs.

To understand the origins of Head Start one must also consider the times in which it came about: the civil rights struggles for social and political justice, the War on Poverty, social intervention strategies for the poor and disadvantaged, and a renewed interest in the role of the environment in human development (Zigler and Anderson, 1979:3). It was a time when the need to prepare children to succeed in school gave Head Start its impetus. However, the ideas that went into the formulation of the program were not new. Ross (1979) has written about this aspect of Head Start:

> The varied aspects of Head Start, although they had rarely been integrated into one scheme, and even more rarely sponsored by the government, all echoed past experiments. The cyclical history of early efforts to improve the health care and education of impoverished youngsters revealed several securing themes. Almost all advocates of early childhood programs believed that the deficiencies of the poor themselves whether hereditary or the result of poor moral, intellectual, or physical training - accounted for the existence of an underprivileged class. High expectations for the ability of education to solve social problems influenced evaluations of programs and often led to disappointment and retrenchment. Child-care schemes themselves often rested on sundry motivations that grew out of immediate but transient crisis. Consequently, no common body of strategy or doctrine had developed before 1965 (p. 21).

Nevertheless, the desire to break the culture of poverty led President Johnson in January 1965 to announce his decision to fund a preschool program. Sargent Shriver, his EOA staff and a host of scholars and community leaders began to develop the Head Start program. Utilizing existing evidence, early planners suggested that a large scale intervention had to include cognitive approaches, parent involvement, medical needs, and nutritional activities (Cooke, 1979:xxiv). This work produced seven original goals which would guide Head Start (Richmond, Stipek, Zigler, 1979:137):

1) Improving the child's physical health and physical abilities;
2) Helping the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity, and self-discipline;
3) Improving the child's mental processes and skills, with particular attention to conceptual and verbal skills;
4) Establishing patterns and expectations of success for the child that will create a climate of confidence for future learning efforts;
5) Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems;
6) Developing in the child and his family a responsible attitude toward society, and encouraging society to work with the poor in solving their problems; and
7) Increasing the sense of dignity and self-worth within the child and his family.

It was immediately announced the program would be launched in the summer of 1965 (Spring, 1976). The underlying assumption of Head Start regarded children living in the culture of poverty to be at a considerable disadvantage in the educational process when compared to children from middle-and-upper income families. The program was to give children of the poor a "headstart" in the educational race so they might compete on equal terms with other children. According to Zigler and Valentine (1979), the basic theoretical premise of Head Start was that intellect is a "product of experience, not inheritence (p. xxiii)."

Once in school the equal chances of the children of the poor were to be maintained through compensatory education which, according to Spring (1976), "was a form of social compensation, for being born into a culture of poverty (p.212)." The education of the disadvantaged was designed to change the culture of the poor into a culture supporting the process of schooling (see also Valentine, 1971:217).

Head Start had five original components which suggested an ideological direction. According to the culture of poverty thesis, health was directly linked to the circle of poverty and poor educational achievement. Thus, Head Start was to provide:

1) Medical and dental services for poor children;

2) Social services for the child's home environment and family, since home and family were considered responsible for low educational achievement, family intervention was seen as logical;

3) Psychological services which emphasized staff consultation and community consideration rather than testing and clinical activities as well as help develop parent involvement and community participation;

4) School readiness programs that emphasized preparing the child to enter school on equal terms with other children;

5) Volunteer services which would enable parents to participate fully in Head Start programs (Spring, 1976:222).

Moreover, although there was little practical experience, there was great optimism about Head Start. The knowledge of scholars and policymakers seemed to reflect the use of "environmental enrichment" as a solution to poverty (Ross, 1976:13). Underlying these assumptions of education and poverty were the notions of researchers and policymakers regarding the goals of Head Start. From the onset of the program outcome measures revolved around increasing the social competence of the child. Zigler (1979) defines the concept in this way:

> By social competence we meant an individual's everyday effectiveness in dealing with his environment. A child's social competence may be described as his ability to master appropriate formal concepts, to perform well in school, to stay out of trouble with the law, and to relate well to adults and children. We have sought to achieve this goal by working with the child directly - providing services to improve his health, intellectual ability, and social-emotional development, all of which are components of social competence. We also work with the child's family and the community in which he lives, since programs that ignore these parts of a child's life cannot produce maximum benefits (p. 496).

Although social competence was the intended goal, there has been an overemphasis on I.Q. measures which have, as a result, deemphasized the role of social competence. Zigler (1979) has identified three factors for this overemphasis. One factor has been the stress given to the "environmental mystique" which holds that with the right kind of intervention, poor children can be changed in order to function at high intellectual levels. A second factor has been the post-Sputnik reaction which saw educators attempting to apply the same overemphasis on cognitive development found in Soviet education to preschool children in the United States. The third factor has been a cognitive emphasis on program evaluations (p. 503-04). Rein (1976), for example, has written about how this situation affects evaluations and oftentimes produce negative results:

> The designers of Head Start saw the purpose of the program as the promotion of social competence, but there was an emphasis on cognitive development in the national evaluations of the program. This came about because academic developmental psychologists imposed the narrower cognitive focus, in part, because it reflected their interests, and in part, because it

> was easier to measure than the fuzzier concept of social competence.

The problem then has been one of defining criteria to measure social competence. Researchers such as Zigler and Trichett (1978) have proposed such a criteria and have suggested that this criteria be used as an outcome measure over I.Q. (see chapter 3). This is important because such criteria also suggests a model for social intervention that goes beyond deficit models by looking at the child as a whole person instead of a victim whose culture, family or environment is blamed for their poverty.

Beyond Deficit Models in Social Policy

The use of deficit models, such as the culture of poverty have been very influential in formulating social policy. Yet, despite the continued influence of these models on policy, social scientists (Valentine, 1968; Baratz and Baratz, 1970; Leacock, 1971; Ryan, 1976) have criticized these models for advancing assumptions which place the blame on the poor for their problems and neglect the cultural patterns of the poor as a means of finding solutions to their conditions. Moreover, Titmus (1974), for example, wrote that "social policy is basically about choices between conflicting political objectives and goals and how they are formulated; what constitutes the good society which culturally distinguishes between the needs and aspirations of social man in contradiction to the needs and aspirations of economic man (p. 49)." The choices made by focusing on the culture of poverty were based on policy objectives which constituted a view of how society should be. But the ensuing criticism of deficit models painted another picture.

Baratz and Baratz (1970) wrote that the ideology of the culturally disadvantaged doomed programs like Head Start to failure because poverty was viewed as pathological as seen in the assumed deficiency of the family.

Social scientists, by ignoring cultural nuances already apparent in poor families, missed the opportunity to utilize these cultural patterns in order to cope with social issues. For example, they write that:

> The total denial of Negro culture is consonant with the melting pot mythology and it stems from a very narrow conceptualization of culture by non-anthropologists. Social science has refused to look beyond the surface similarities between Negro and White behavior and, therefore, has dismissed the idea of subtle yet enduring differences. In the absence of an ethnohistorical perspective, when differences appear in behavior, intelligence, or cognition, they are explained as evidence of genetic defects, or as evidence of the negative effects of slavery, poverty, and discrimination. Thus, the social scientist interprets differences in behavior as genetic pathology or as the alleged pathology of the environment; he therefore fails to understand the distortion of Negro culture that his ethnocentric assumptions and measuring devices have created (p. 32).

Baratz and Baratz's concluded intervention programs based on deficit assumptions fail after initial gains in I.Q. scores. While the catch-up process works for a couple of years, the decrease in gains only show the schools are not succeeding (Baratz and Baratz, 1970:41; Ryan, 1976:38). Similarly, Ross (1979) found that the impact of intervention programs decreased if not supported by a good home environment and positive grade-school experiences. This complements the position of Stipek, Valentine, and Zigler (1979), who write: "It seems evident now that preschool intervention with the disadvantaged cannot be expected to contribute to the elimination of poverty, since poverty in America has its roots in other, noneducational aspects of American society (p. 480)."

The Final Report of the Impact of Head Start on Children, Families, and Communities-Head Start Evaluation, Synthesis, and Utilization Project (McKey, et. al. 1985), (referred to as the Synthesis Project throughout this report), found that:

> One year after Head Start, the differences between Head Start and non-Head Start children on achievement and school readiness tests continue to be in the educationally meaningful range, but the two groups score at about the same level on intelligence tests. By the end of the second year there are no educationally meaningful differences on any of the measures (p. 8).

Another critique (Ryan, 1976), claimed deficit models failed to address the problems which affect inner-city school children, but goes one step further. Deficit models were vehicles for "blaming the victim". It is a problem which is evident throughout American society and is so potent that it has taken the form of ideology. Ryan (1976) states:

> Blaming the victim is, of course, quite different from old-fashioned conservative ideologies. The latter simply dismisses victims as inferior, genetically defective, or morally unfit; the emphasis is on the intrinsic, even hereditary defect...The new ideology attributes defect and inadequacy to the malignant nature of poverty, injustice, slum life, and racial difficulties. The stigma that marks the victim and accounts for his victimization is an acquired stigma, a stigma of social, rather than genetic, origin. But the stigma... is still located within the victim, inside his skin...it is a brilliant ideology for justifying a perverse form of social action designed to change, not society, as one might expect but rather society's victim (p. 7-8).

This view of the victim was dominant. One only need to review the testimony of R. A. Cloward to the Senate Select Subcommittee on Poverty (1965) in which he states:

> The chief target of the federal anti-poverty program is the victim of poverty, not the source of the victimization. If fundamental institutional change is not the primary object of the anti-poverty program, massive individual remediation is, and this is the sense in which the program does not constitute a plan to attack longstanding social and economic inequalities in our society (p. 231).

This type of policy has been scrutinized carefully since the earliest beginnings of the War on Poverty. Critics suggested social intervention programs were misdirected due to assumptions reflecting the view that poor people would not ever leave their conditions without government help and education. This view was further strengthened by ignoring the factors which led to poverty and inequality in our society. Bronfenbrenner (1979a) has examined deficit models and cites the destructive process inherent in these orientations:

> A significant factor in this destructive process has been the alienation and antagonistic orientation implicit in the deficit model. In addition to further isolation and demeaning the victims on environmental stress, it has led to the development of counteractive strategies that ironically exacerbate the very difficulties they are intended to abate. The definition of a multiplicity of problems generates a multiplicity of uncoordinated programs, each addressed to an allegedly separable segment of the person or his family. This categorical approach has given rise to the bureaucracy that tends to dehumanize not only its clients but also the staff whose assigned mission is to render human service (p. 102).

What Bronfenbrenner has said above and elsewhere (with Weiss, 1983) is that deficit models pervade every aspect of our society, especially in the human service field where, in order to receive help, it must be demonstrated one's condition warrants such assistance. Or put another way, one must show their family and home life to be inadequate. The affect of such policies has, according to Bronfenbrenner and Weiss (1983), taken "a substantial toll on the individual's self-esteem and the family's capacity to function (p. 396)."

But recently, a new perspective has arisen which calls for a shift in policy and with it, a new perspective towards children and families. The call is for policies which counteract conditions which affect the family's ability to cope with their environment; a call for policies which go beyond deficit models. Bronfenbrenner and Weiss (1983) suggest the concept of ecology of human development - defined as the "scientific study of the progressive, mutual accommodation between the developing person and the changing properties of the immediate and broader contexts in which the person lives (p. 393)." Public policy represents one such broader context. Specifically, this means policies, as proposed by Bronfenbrenner (1979a), where:

> The strategy of choice becomes that of building interconnections between the settings in which people live out their lives, so that family roles receive recognition and validation outside the home in the contexts of preschool, school neighborhood and work. Such a strategy calls for social policies that are much more decentralized than ones currently in effect, policies that provide flexible resources rather than packaged programs, and offer tax and other incentives for local initiative in both the private and the public sector (p. 103).

The question, therefore, is how can effective support systems be introduced where they do not now exist? Attempts at alternative programming have included strategies where parents work with their children to improve school performance (Smith, 1968); others have called for community control of the schools (Wilcox, 1968); while others have even gone so far as to propose alternative public school systems (Clark, 1968). In doing research on Head Start and suggesting an ecological orientation in working with children and families, it should be kept in mind the words of Richard Titmus (1974) who writes:

> An essential background for the study of social policy is a knowledge of population changes, past and present and predicted for the future; the family as an institution and the position of women; social stratification and the concepts of class, caste, status and mobility, social change and the effects of industrialization, urbanization and social conditions; the political structure; the work ethic and the sociology of industrial relations; minority groups and racial prejudice; social control, conformity, deviance and the uses of sociology to maintain the status quo.
>
> Policy, any policy, to be effective must choose an objective

> and must face dilemmas of choice. But to understand policy, to distinguish between ends (what we want or think we want) and means (how we get there), we have to see it in the context of a particular set of circumstances, a given society and culture, and a more or less specified period of historical time. In other words, social policy cannot be discussed or even conceptualized in a social vacuum (p. 15-16).

The current report follows these steps and with good reason. A report published by the U.S. Department of Health and Human Services (1980) suggests a shift from a child-centered approach currently used in Head Start to a family-centered approach. For one thing, many of the child-centered programs which still exist originated in the maternal and child study groups developed during the progressive era of American education in the 1920's and 1930's (Cremin, 1964; chapter 4 in Lightfoot, 1978; chapters 8, 9 and 10 in Button and Provenzo, 1983). Based on the ecology of human development, the findings found in this report represent a sound step in the delivery of comprehensive mental health services to children and families in Head Start. The MHP/IP proposes a comprehensive model for mental health service delivery, relying on all Head Start components for its success and most importantly, sees the role of parents as a major aspect in its contribution in strenghening child and family competence.

Chapter 2

THE EVOLUTION OF MENTAL HEALTH THEORY AND PRACTICE

Overview

This chapter will examine the evolution of mental health theory and practice. The history of mental health will be traced from its origins to the present time. A definition and discussion of prevention and its implications in the field of mental health is also discussed. In addition, chapter 2 will address the development and practice of mental health in Head Start. LACA's mental health program development, treatment ideology, and existing service delivery is presented. The chapter ends with a discussion of the implications and long range effects of mental health programming to a high-risk population.

History of Mental Health

The historical antecedents of the mental health movement began in the pre-christian era with contrasting concepts of mental health disorders. The concept of demonology, for example, proposed that psychiatric disorders were caused by supernatural forces and people with such psychiatric disorders had been invaded by "evil" spirits and thus had become "evil" themselves (Bloom, 1984). In contrast to the view of demonology were the ideas of Hippocrates and other Greek physicians of the pre-christian era. They believed the origins of psychiatric disorders were from natural causes rather than supernatural ones, and physicians, rather than priests or healers, should provide treatment. Although the Hippocratic view was different from the concept of demonology, in actual practice, treatment methods were similar and included purging, bleeding, blistering and giving drugs to the patient to cause vomiting (Bloom, 1984).

The development of the first psychiatric hospital in the 15th century saw a new direction in the care of the mentally ill. Patients were encouraged to seek admission voluntarily and discharge occurred as soon as they were able to function in society. Efforts were also made to avoid isolating patients from the community. Between the 15th and 19th century the development of mental hospitals began in Europe and the United States.

By the 19th century, the growth of urban populations increased and so did the number of people with severe mental problems. Bloom (1984), for example, states that one movement for those of financial means advocated restorative or strengthening treatments, including bed rest, cheerful environment and good nutrition. This approach was endorsed by both those who believed psychiatric disorders were diseases of the spirits and by those who believed they were diseases of the body. As a result, the concept of the "retreat" was developed so those suffering from mental anguish could experience an environment free from the stress and pressure of everyday life. This period of time became known as the era of "moral treatment". But this humane and disciplined approach was destined to disappear as the number of the mentally ill increased.

During the first half of the 19th century in the United States, there were few public facilities for the humane treatment of the mentally ill. During the second half of the century, there arose the emergence of the state mental hospital movement "and the professional orientation toward the insane had been changed from seeing them as no different from paupers or criminals to seeing them as sick people in need of hospital care (Bloom, 1984:7)."

In 1898, for example, Witmer developed the first psychiatric facility for children. He discovered the potential risk of pathology could be reduced for children and adolescents through treatment. The Jane Addams Hull House

Movement, which provided social adjustment interventions, was perhaps the only other new creative model developed to address the needs of low income children and families. During this period, psychiatrists were particularly concerned with children and prevention of illness through public education. The primary causes of insanity were believed to be a result of "defective education and injudicious early training". Parents were told about the implications of leaving children in the care of others, and an early education at home was considered essential for normal growth and emotional development (Rappaport, 1977). This interest in early education is still predominate today but the targets for such education have changed. With professionals as well as parents now acting as the agents of early education, the focus of education is, for the most part, now placed on directing a child toward academic productivity; that is, achieving higher I.Q.'s rather than on a combined focus of cultivating both intellectual and moral character.

In the first half of the 20th century, the course of psychiatry was greatly influenced by Freud who inadvertently transformed the field by introducing individual psychotherapy as an innovative modality in the treatment of psychiatric and emotional disorders. In summarizing the new introductory lectures on psychoanalysis by Freud, Bettleheim (1983), stated:

> Freud admitted that he was never really enthusiastic about psychoanalysis as therapy...Freud recommended psychoanalysis to our interest 'not as therapy but rather because of what it reveals to us about what concerns man most closely; his own essence; and because of the connections it uncovers between the widest variety of his actions.' His greatest hope was with the spreading of psychoanalytic knowledge, and the insights gained through it, the rearing of children would be reformed. Freud considered this 'perhaps the most important of all activities of analysis,' because it could free the largest number of people - not merely the few who underwent

> analysis personally - from unnecessary repressions, unrealistic anxieties, and destructive hatreds (p. 32-33).

In the treatment of children, the relationship between psychiatry, hospitalization and community care had been most influenced by the severity of the diagnosis and the degree to which care for basic human needs were required. Psychiatrists generally looked for organic treatments, and rejected "moral treatment "which was not medical in character. Psychiatric hospitals, particularly state institutions, remained the caretakers of many autistic or neurologically handicapped children who required twenty-four hour care.

The first involvement of the federal government in mental health came as a result of World War II. Levine (1981) writes:

> After the Second World War, Veterans Administration training programs were critical for the mental health field. A crash program supported graduate training, internships, and residencies in psychology, social work, and psychiatry. New clinics and hospitals were built, often adjacent to universities or medical centers, with many attractive jobs. In the immediate postwar period, the Veterans Administration mission to care for the returning veteran dominated mental health efforts (p.35).

The field of psychopharmacology also emerged and introduced new drugs to be used in the treatment of psychiatric disorders thus speeding up the the discharge of patients. Treatment through drug therapy reinforced the medical model for treatment. Levine (1981) adds:

> The drugs did not cure, but they did reduce the most distressing symptoms. Wards could be unlocked and patients discharged. Moreover, drugs could be produced and administered on a mass basis. Because we now had drugs that effectively controlled symptoms, we needed community based services more than every before (p.45).

The Community Mental Health Act of 1963 envisioned placing increasing responsibility for the mentally ill and the mentally retarded in the hands of local communities on the assumption that local responsibility would lead to more conscientious care. A major intent of this legislation was to eliminate unregulated care by providing better care to people classified as "social problems". Local responsibility for the care of the dependent population, however, had proven to be unsatisfactory because local governments did not have the necessary resources or had been reluctant to use their resources for the care of the dependent population (Levine, 1981).

The goal of community mental health was to provide effective comprehensive services to the mentally ill in addition to promoting the social-emotional well-being of the population at large. Yet a review of the literature indicated that federal health policy did not achieve this original goal. It was partly out of unhappiness with this state of affairs that the field of community psychology grew (Rappaport, 1977). One characteristic which distinguished community mental health from more traditional mental health activities was its attempt to emphasize practice in the community rather than in institutional settings. Community mental health was designed to focus on disease-preventive health services, and on innovative clinical strategies created to meet the mental health needs of large numbers of people more promptly, effectively, and efficiently than had previously been possible (Bloom, 1984).

Severe cuts in government funding over the recent years, however, have reduced the availability of needed mental health services. Moreover, of the available monies, the priority for funding in mental health centers has been placed on treating the chronically mentally ill in the form of hospitalization, day treatment and board and care facilities (California State Mental Health Plan, 1984), even though the chronically mentally ill in California are only one segment of the population of which the mental health system is responsible for serving. The lowest priority in funding, on the other hand, has been for children, families, ethnic minorities, high risk populations and in community mental health system, as evidenced by the lack of clinicians trained to work with these groups. In addition, for the increasing number of ethnic minorities in the U.S., there are few trained clinicians who are bilingual, let alone bicultural or culturally sensitive. Consistently, prevention has received the lowest priority in funding. These barriers to treatment have been proposed as some of the reasons for the underutilization rate of mental health services by ethnic minority groups, including Latinos. In addition, the issue of lack of funding has been compounded by the theoretical view, which until recently, has seen the child generally treated in isolation from the family.

Various studies demonstrate the high prevalence of mental disorders in the general population. The National Institute of Mental Health's Epidemiological Catchment Area Program (1984) reports figures of 28%-38% for lifetime prevalence of specific psychiatric disorders. The most common disorders found were phobias, alcohol abuse and/or dependence, dysthymia, and major depression. Despite these high percentages of mental disorders, only 6% to 7% of the adults made a visit during the prior six months for mental health reasons.

In another epidemiological study, O'Regan, Reinhertz, and Haworth (1980) state that young children have been designated as among the most vulnerable groups for mental health problems: "Results of the community based studies of pre-school children suggest that from 7% to almost 20% of these children may have moderate to severe behavior problems" (p. 3). They state that children of certain demographic groups have an even greater prevalence of problem behaviors.

Those groups include mothers with less than high school education, low income persons, and single parent families. Moreover, the Synthesis Project (McKey, 1985) has shown that Head Start has had a mixed impact on parent's child rearing practices. Other studies report small positive effects on parents' relating to their children and other studies have shown no effects.

Prevention

A review of the literature indicates community mental health consultation is an important strategy for prevention: first, as an intervention and second, as a philosophy of helping communities and social settings to increase shared social competence and empowerment. According to Hodges and Cooper (1983) community mental health consultation can be defined as:

> The process by which a mental health professional interacts with community-based professionals and other service providers (the consultees) to supply information, skill training, and individual-process change or system change in order to help the consultee or the system better serve the mental health needs of the people in the community (p. 19-20).

Within the system of community mental health, the concept of prevention has been central to the type of therapy offered to the public.

As stated by Leavell and Clark (in Goldston, 1977), "In public health terminology, prevention is an all embracing concept having three distinct levels: primary prevention, referring to actions taken prior to the onset of disease to intercept its causation or to modify its course before man is involved; secondary prevention, meaning early diagnosis and treatment; and tertiary prevention, indicating rehabilitative efforts to reduce the residual effects of illness (p. 19). According to Cowen (1984):

> The ultimate goal of primary prevention in mental health is to develop programs (interventions/actions) to forestall psychological problems and/or to build strengths or competencies that favor psychological wellness. It is an

> intentional outreaching approach, targeted to groups of well people including some at risk before the fact of maladjustment. So viewed, its two main strategies are: (1) to reduce sources of stress on, and increase life opportunities for, people, i.e., a system level strategy; (2) to develop interventions to enhance people's capacity to adapt effectively and to deal with stressful situations and events, i.e., a person centered strategy (p. 6).

"Before-the-fact-intervention," according to Caplan (in Rappaport, 1977), has led some mental health professionals into programs which have moved away from traditionally oriented mental health programs. Caplan's ideas reinforce Rappaport's notion that primary prevention programs must be aimed at identifying both helpful and harmful environmental factors which influence a community's ability to cope with the stresses of life. Secondary prevention, however, refers to the decrease of disorders by lowering its prevalence, of the incidence of identified cases in a given population at "risk". Rappaport (1977) says this decrease of incidence may occur by changing the condition which causes new cases, or by decreasing the duration and/or severity of cases through early diagnosis and treatment. In addition, he states that secondary prevention in contrast to tertiary prevention is built on the idea of identifying the problems before they become mental disorders. Caplan suggests one means of early identification of problems is to encourage early referral for treatment as soon as a problem is suspected. He views public education as one means of encouragement which includes the description of the symptom and where to go for help.

Tertiary prevention, on the other hand, refers to the reduction of incidences of mental disorders in a community. Rappaport (1977) believes in order to reduce the duration and destructiveness of mental disorders the term "tertiary prevention" should embrace programs aimed at large scale rehabilitation of those already suffering from mental disorders. Caplan (in Rappaport 1977), says rehabilitation refers to work with individual clients, while tertiary prevention refers to efforts to decrease the incidence of problems in a community at large.

The research on prevention also indicates that since its creation, in 1948, the National Institute of Mental Health (NIMH) has encouraged, supported, and developed a variety of imaginative and forward-looking programs. However, with respect to prevention, NIMH's efforts have been and remain underdeveloped and unfocused (Levine, 1981). While many aspects of the total NIMH program may be viewed as primary prevention in general, what prevails has been more of a token investment rather than an adequate response to the challenge prevention represents.

According to Cowen (1984), the decade between 1974-1984 was a period of collecting and analyzing germinal ideas which could potentially lead to a new mental health revolution. A few primary prevention programs have been created which have demonstrated at least a short term effectiveness. In comparison to what the field of prevention has provided and considering the short time period, the results were relevant and significant which proved even further the need for such interventions. These initial "baby steps" should not be confused with the need for more substantial long-term demonstrations and research in the field of prevention which could then be worthy of being called a full scale "revolution". Primary prevention began its journey in this last decade, took form and ran an early unbridled course. By looking at prevention critically, its ultimate goal could be implemented and thus also stimulate a richer decade of innovative and far-reaching programs. Realistically assessing the strengths and weaknesses of prevention programming can lead to informing a next, more disciplined, more productive decade of accomplishment in this area (Cowen, 1985:39). However, as Goldston (1977) has stated: "The entire field of prevention has consistently been characterized more by rhetoric than by action...Rhetoric aside, prevention is neither smoke nor a cloud, nor a rosy vision for a happier tomorrow, but specific actions directed to a specific population (p. 19)."

One program which addressed the issue of prevention was the Child and Family Mental Health Project (CFMH) which was developed in 1977 as a demonstration/research model for Head Start (Stone, Pendleton, Vaill, Slatin, Mitcham, Georgette, 1982). The model focused on training and consultation; direct services to children and families were not stressed. The program was originally set up as a four-year demonstration/research model. However, during the third year the funding was stopped and as a result there was no outcome evaluation.

The potential for prevention and treatment intervention in the area of mental health services for Head Start children and families has become recognized as critical (Cohen, et. al., 1979). The theory of prevention asserts that through early identification and intervention the high incidences of these problems will be reduced. And yet, no model for prevention, identification and intervention, has been demonstrated as an effective strategy for mental health services with a Head Start population.

Development & Practice of Mental Health in Head Start

Since Head Start was established in 1965, it has grown into the largest comprehensive child development program in the United States. This program was developed to give low income children a "head start" in preparation for the educational system and their lives. The original Head Start planning group recognized the lives of these children and families were burdened by a set of related difficulties. To facilitate development, the program would have to be attentive to many areas: a child's physical health; opportunities available for learning and play; quality of life in a community; the state of a child's family; the relationship between the child, the family and the community; and the inner balance and forward movements of the child's emotional life. The components of Head Start reflected these areas of concern. However, the implementation of this expansive concept of Head Start has been uneven at best.

There have been great variations among regions of the country, differences in the interests and style of local program administration, and varying concerns of Head Start directors. In spite of variation, the national Head Start program could be said to have placed its greatest emphasis on the preschool child's achievement of lasting intellectual skills through early cognitive oriented education (Cohen, et.al. 1979). In comparison, there has been little explicit attention given to the child's emotional development and psychological difficulties. Head Start has undergone a variety of changes over the years, but of all the components what was originally known as psychological services and now known as Mental Health, has been the least visible, least adequately funded and least valued (Cohen, et.al., 1979).

For the most part, the mental health components in Head Start receive referrals on children in the program and then refer them to outside agencies. However, research has shown this low income population will rarely use available community mental health services. The reasons include their belief the family should be able to manage its own affairs, their distrust of bureaucracy, and for the increasing number of ethnic minorities, the lack of bilingual and culturally sensitive counselors (Barrera, 1978). Mental health services to children, families and minorities typically receive the lowest priority in funding (Children's Defense Fund, 1982). Low income families and their children experience more stress and therefore, a greater potential for high risk in health and mental health disorders than the typical population of preschool age children and their families. The President's Commission on Mental Health (1978) indicates extensive evidence has led to the conclusion poverty increases the risk for serious psychiatric and developmental disturbances. Almost any disorder - schzophrenia, alcohol and drug addiction, retardation, depression, epilepsy, severe learning disturbance and delinquency - is more likely to occur with a high risk population, sometimes at a rate several times greater than with the mainstream population. Research also shows 10-25% of Head Start children were thought to suffer from serious developmental and psychiatric disturbances. Cohen, et.al., (1979) indicates that:

> The consensus among clinicians was that if many of these Head Start children were seen in private practice consultation and were from middle-class families, serious developmental and psychiatric disturbances would be diagnosed. Did the symptoms and signs of developmental delay and irregularity have a different meaning in the offspring of the poor (p. 206)?

It is estimated that two million of the three million seriously emotionally disturbed children (66%) in this country do not get the mental health services they need. (Children's Defense Fund, 1982). This figure does not even begin to take into account the children who are beginning to show signs of emotional problems.

The main goal of Head Start is, according to Zigler and Valentine

(1977), to increase social competence in children of low-income families. The performance standards state the goals and objectives for the Head Start program and provide a set of guidelines for service delivery. However, the goals and objectives of these standards have been interpreted in a number of ways. As stated, Head Start has focused primarily on a cognitive approach, thus there has been little understanding and, therefore implementation of the original goals of the Head Start program. In addition, there has been little comprehension of the goals of mental health in Head Start for reasons which include stigmas attached to mental health, educationally oriented administrators; and after 20 years of Head Start, only two mental health professionals have been responsible for mental health at the National Head Start Bureau for less than 5 years. Cohen et. al., (1979) writes, for example:

> The extent of the undervaluation of psychological expertise can be brought out most dramatically by comparison with the educational component. For example, throughout its history, Head Start was heavily engaged in the development of preschool curricula. Large sums were spent on writing new curricula, implementing them, and evaluating their short and long-term cognitive effectiveness. In this process, educators were central to the Head Start program at all levels. In contrast, Head Start administrators showed relative apathy toward the special knowledge of mental health professionals working with the families, in improving children's self-esteem, in detecting emotional difficulties, in altering communal values, in treating sick children, and in other potentially critical aspects of relevant concern (p.278).

Since accountability has not been built into the system towards quality programming, agencies have run maintenance mental health programs in order to meet compliance. It has been observed by the authors that within Head Start, one person usually supervises two or more components (i.e., one person may supervise social services, handicap, and mental health). In fact, the authors have consistently observed, in these cases, that mental health has been the component which has received the least attention. In 1985, as a typical example, one agency serving over 800 children reported having a $60,000 dental budget, a $62,000 handicap budget, and a $5,000 mental health budget.

According to current federal guidelines, Head Start can either hire a mental health professional or mental health coordinator (para-professional). Usually both of these people contract with mental health consultants who are the direct providers of mental health services to children and families. However, in-house psychotherapy is rarely provided. The authors have found for the most part, that the services given have not met the needs of this high risk population due to the following:

1. Head Start has attracted consultants who many times have lacked experience with Head Start, preschool children, families, minorities, and high risk populations;

2. Mental health staff has generally not had the needed bilingual language capabilities and cultural sensitivity to serve the growing number of non English speaking populations;

3. Consultants have generally lacked an ongoing relationship and involvement in the overall Head Start program and have provided minimal hours of services;

4. There has been little accountability built into the system for quality services and follow-through. Therefore, insufficient, and uneffective service delivery have resulted.

There are 31 Head Start agencies serving over 11,000 children in Los Angeles County. For example, 13 of these agencies are delegate agencies and 18 are part of existing school districts. The Los Angeles County Office of Education, the Head Start/State Preschool Grantee, compiled an agency mental health activities report, for September 1 to December 31, 1984. Data collected from 24 of those agencies and school districts have indicated the following:

1. Four of these agencies have staff mental health specialists. Three of those four supervise two or more components.

2. Of the 24 agencies, only one agency (LACA) provides direct mental health services as part of their service delivery plan.

3. The 23 remaining agencies contract with consultants.

4. Time spent by the mental health specialist in providing services to the agencies ranged from 6 hours to 60 days (LACA), with a mean of 3½ days.

5. Number of children referred to the mental health component ranged from 0-111 (LACA) with a mean of eight.

6. Percentage of children ranged from 0-11% with a mean of 2%. A total of 458 children were referred to the mental health component, representing 4% of the total enrollment.

7. Number of children referred to outside agencies for mental health services ranged from 0-14, with a mean of 2. The total number referred to outside agencies was 62, representing less than ½% of the Head Start population.

8. Los Angeles County recommends 1 hour of mental health observation per site (a site can have as many as 4 classes/64 children). (Office of Education, Head Start/State Preschool Summary data-agency activities report, 1984).

The data presented above reflects what has been concluded from the literature. Mental health has not been a priority in Head Start and there has been little focus on prevention, identification, and service delivery. For example, of the 24 reporting agencies in Los Angeles County, the median percentage of children referred to the mental health component was 2%. In the authors' opinion this data not only reflects the state of affairs of mental health in Head Start in Los Angeles County, but it also reflects the state of affairs of mental health in Head Start across the nation. Data shows 10% to 25% of the children in Head Start classrooms are in need of mental health services contrasted with the ½% of children in Los Angeles County referred to mental health agencies. Is it that only ½% of the children in Los Angeles County are in need of mental health services, or is it there is no priority and understanding of mental health and consequently the children who are in dire need of mental health services are not getting referred? The authors believe the latter is true as evidenced through the findings in this study.

The Synthesis Project (McKey, 1985), which assessed the impact of Head Start on children, families and communities, shows no significant evaluations on the impact of mental health on Head Start families. Little is known about how mental health service delivery in Head Start affects children and families. It is the authors' belief that the field of staff consultation has been given little attention. The potential for providing consultation to teaching and support staff has the potential of having long range effects for Head Start families. The Synthesis Project (McKey, 1985) also reports no data on the impact of staff consultation in Head Start.

Dr. Cynthia Barnes is the Executive Director of the Manhattan Children's Psychiatric Center (MCPC) which serves as the state children's psychiatric hospital for the borough of Manhattan in New York City. Manhattan Children's Psychiatric Center serves children and youth between the ages of 6-18 who have severe emotional and behavioral problems which require in-patient hospitalization or attendance in their day treatment program. In a meeting with one of the authors' at the National Head Start Conference in Puerto Rico, May 1985, Dr. Barnes indicated that 80% of the children at Manhattan Children's Psychiatric Center had previously attended Head Start. Nevertheless, only 10% of these individuals had been identified while enrolled in Head Start. The remaining 90% were not identified, in most cases, until they reached the second grade, and were generally incorrectly referred for speech and language problems, not the severe psychological problems they were having. For the most part, these problems were present when these children were enrolled in Head Start, yet without early identification and intervention the problems became so severe that in-patient hospitalization was required. If there had been a focus on mental health prevention and treatment in Head Start, these children might have been identified early on, received treatment, and quite possibly may have avoided institutionalization.

Is it that no evaluation studies to assess the impact of mental health services on children have been undertaken, or is it there are no comprehensive mental health services in Head Start to be evaluated? One way to confront the high percentage of children and families needing mental health services was to design a comprehensive program that could fill the gap left by Head Start policy.

The MHP/IP proposed a model for prevention, early identification and intervention which can become the state-of-the-art for mental health in Head Start and provide a model for national change in the educational system. The potential for prevention and treatment intervention in the areas of health and mental health for Head Start children and families has become recognized as critical. The theory of prevention claims that through early identification and intervention, the high incidences of the severe problems addressed by the authors' will be reduced. And yet, no model for prevention, identification and intervention has been demonstrated as an effective strategy for mental health services with this high risk population.

Latin American Civic Association's Mental Health Program: Development, Treatment Ideology and Service Delivery

The literature demonstrates the need for quality comprehensive mental health services to serve the severe needs of high risk families and children. As a result of this awareness, LACA submitted a proposal entitled, "Strengthening Head Start Families: Reducing High Risk through Mental Health Prevention/Intervention (MHP/IP)." This research and demonstration project was designed to assess the effectiveness of mental health services to a Head Start population. Three preventive mental health interventions were tested: (1) staff training and consultation (2) parent education and involvement; and (3) in-house mental health treatment services including short-term psychotherapy.

The Department of Health and Human Services (1980) has suggested a shift from a child-centered program to a family-centered program. To complement this view the authors believe children should no longer be viewed in isolation from the family. Rather, the family needs to be seen as an integrated unit. Problems which affect one, affect the whole. To date, Head Start has had its primary focus on cognitive oriented education with a focus on the educational component. The MHP/IP proposed all Head Start components work cooperatively and interdependently to serve the Head Start child and family to achieve child and family development in the fullest sense - allowing the primary goal of Head Start to be the promotion of social competence. In this regard, the authors proposed a shift from a program which has primarily emphasized cognitive development with all the components serving the education component, to a program which focuses on developing social competence in Head Start children and families where all components, including education, serve the Head Start child and family. Referring to the ecological approach discussed in chapter 1, the authors' stress that the child is not just a cognitive entity alone. He has a physical body, a social/emotional essence, and a cognitive mind. The child should be viewed as an integral being who interdependently relates to his family, community and society.

In the MHP/IP, the child and family are viewed from a holistic, "systems" orientation. A multi-vectored ecological model of treatment is used combining biological, psychological, social and environmental factors. For example, if a child were referred to mental health for aggressive behavior, the counselor assessed if there were biological or organic factors precipitating the aggression. The psychological well being of the child, the siblings, and the parents were evaluated in assessing the problem; the social structure, extended family, culture and societal pressures were also assessed to see how they affected the child and the family.

Parents were viewed as the primary educators of their children. Family strengths and problems were viewed from the standpoint of cause and effect. Focusing on the child alone (who usually manifested the effect and/or symptom of the family dynamics), the origin of the problem rarely gets resolved. One of the program's objectives was to show that as parents underwent changes, those changes directly affected the children and the entire family. This point underscored the need for a shift from a child centered program to a family centered approach. In addition, the MHP/IP provided staff training and consultation to increase teacher's skills in fostering an emotionally healthy and supportive classroom environment. Focus was also placed on promoting positive attitudes toward mental health, and shifting the existing focus in mental health from pathology to health and wellness. Counselors were employed who were bilingual and culturally sensitive to their client's needs.

Moreover, a mental health program that services primarily a high risk population has to go beyond the tradition of emphasizing primary prevention to a mainstream population. If only traditional preschool programs were offered to high risk populations, then the children would not have a "head start" in the educational system and their lives, and there would be no remediation offered to the severe problems a high risk population are faced with. Head Start provides a short-term one year intervention into the lives of high risk children to prepare them for the educational system and their lives. This is what a mental health prevention program should do.

The MHP/IP provided a model for prevention, early identification, and intervention. As previously mentioned, prevention is an all-encompassing concept having three distinct levels: (1) primary prevention, (2) secondary prevention, and (3) tertiary prevention.

Primary prevention refers to actions taken prior to the onset of problems. In this study, the goal of primary prevention was to enhance parent-child-teacher interactions, both in the classroom and in the home. Parents were supported as the primary educators of their children. The provision of parent education, the use of volunteer parents as part of the mental health service component, and an increase in the utilization of helping services by Head Start family members were used as a means of directing parents, and therefore their children, towards improved social competence in the enhancement of their own lives.

Secondary prevention refers to early diagnosis and treatment. During the early months of the program, all 960 children in the program received a 4 hour observation in each classroom followed by a 2 hour training and consultation with the teaching staff. The mental health counselor and the Child Development Specialist (CDS) did a joint supervision/observation cycle. The result was early identification of children with problems and prompt referral to mental health and/or appropriate components. As a result, children were referred to the program for services including short-term psychotherapy with their families. Counseling staff provided early intervention which offered the opportunity to identify and reduce social or psychological dysfunctions which traditionally have not been addressed on this level.

Direct therapeutic services were provided in the following manner: referrals were initiated by the teaching staff, parents and/or support staff. If the referral were on a child, a mental health counselor consulted with the teacher, observed the child in the classroom, conducted a parent/teacher conference to discuss the problem and to explain the mental health services and process. A preliminary session with the parents alone, followed by a screening session with the entire family took place. Any adjunctive services needed to evaluate the problem were also provided at that time, (i.e., medical evaluation, referral to handicap services, and/or appropriate components). The case was then staffed and recommendations were made for treatment. An interpretive session was held with the parents and a decision was jointly reached as to the course of treatment. Such treatment took the form of one or a combination of the following: family therapy, conjoint therapy, play therapy, individual adult therapy, parent education and teacher education. A plan was made to train the teacher and support the child in the classroom. Eight weeks after the case was closed, a final review was conducted to evaluate the status of the case and determine whether the results of therapy were successful or whether additional treatment was needed. The counselor advised the family on the utilization of other community resources and referrals when needed.

Tertiary prevention indicates rehabilitation efforts to reduce the residual effects of illness. Children who needed long-term intervention were referred to handicap services. The mental health and the handicap components coordinated service delivery to these children and families. Those families who were thought to benefit from continued therapy when the program year ended were encouraged to do so, and were referred to the appropriate agencies.

Cost Effectiveness

The MHP/IP was based upon the assumption that children who demonstrate problems in development can be helped best when worked with at a very early age. During the program year 1982/83, 22% of the total enrollment of LACA was referred to the mental health component for psychological services; during program year 1983/84, 23% were referred, and during program year 1984/85 21% were referred. LACA's data concurs with national research which has shown that 10-25% of Head Start children are thought to suffer from serious developmental and psychiatric disturbances (Cohen et. al., 1979). In addition, it has been reported by NIMH, that 20% of the children of high risk families are in need of mental health services.

A basis for the belief in early intervention is found in prior research: Weber, Foster and Weikart (1978) and Schweinhart and Weinkart (1980) reported that children who participated in the Ypsilanti Perry Preschool Project had significantly reduced need for special educational services or grade retention in their public school years.

An important assumption in projecting cost-effectiveness for the MHP/IP were the results of early intervention through the provision of mental health services similar to those secured through early education - that the children would become socially competent and able to achieve within the regular educational system as they enter and progress through public school. Several studies can be cited which address the issue of cost-effectiveness for early intervention. Wood (1980) reviewed the cost of providing special education intervention at various age levels. The data collected indicated that the cost per child to age 18 decreases as the age of intervention decreases (e.g., intervention at age two = $37,600; intervention at age six = $56,816; intervention at age six with no eventual movement to regular education = $53,340). Thus assuming a $2,304 cost each year in which a student is not involved in an intervention program between the ages of two and six, the cost of education per child to age 18 receiving intervention at age three, would be $39,904. This is a savings of $6,912 per child if contrasted to intervention at age six. Additionally, assuming early intervention leads to placement within the regular education setting, the average per child savings would be $13,436.

Finally, if a cost/benefit analysis were constructed, additional consideration would be given savings which result from taxes recovered from earnings, income maintenance reductions, and institutional avoidance (special schools and penal, as well as, mental health institutions), for example, mental institutionalizations average $50,000 per year (L.A. County Department of Mental Health, 1984). The budget for the MHP/IP was $125,000. $96,000 of this amount covered direct mental health services for 960 children. Therefore, the cost was $100.00 per child per year. Head Start presently serves approximately 400,000 children. If mental health services were provided at a cost of $100.00 per child per year it would cost $40 million per year. Head Start's present budget is $1 billion per year and the $40 million per year that is being proposed for mental health represents 4% of the total budget.

"High risk" is a major factor in the developmental and emotional delays of children who are impacted by these problems at an early age. One of the goals of this study was to assess the framework of the environment from which the child receives his/her potential for individual growth and thus, social competence. The ability to control one's environment through new skills for living will have far greater and long range impact than simply the one year of educational learning for both the child and the family. This must be the important value of Head Start.

Chapter 3

SOCIAL COMPETENCE

Overview

This chapter addresses issues reflecting the concept of social competence and its relationship to the goals of Head Start. Historically, the promotion of social competence of the child was the main goal of Head Start. How this came about and how conflicting issues in Head Start changed the focus from social competence to cognitive development is the subject of the first part of this chapter. This is followed by a brief discussion on the basic differences between I.Q. tests and social competence. The next section discusses attempts to develop a definition of social competence as recorded in the literature and finally, closes with a discussion of the MHP/IP emphasis on social competence.

Social Competence as the Primary Goal of Head Start

Head Start's performance standards state that social competence is the primary goal of Head Start. However, due to Head Start being primarily focused on a cognitive approach and with no clear definition and operationalization of social competence, an effective way of measuring the gains of Head Start children has yet to be explored (Zigler and Trickett, 1978). Thus, with the emphasis on I.Q. as being central to the outcome of the program, and due to the non-existence of an original plan of how to evaluate the program, social competence, as a goal, has not been realized. Evaluation studies emphasizing cognitive gains, for the most part, have been controversial and confusing (Zigler and Rescorla, 1982).

The question of how to measure the effectiveness of Head Start goes back prior to the beginning of the program, in the summer of 1965, when the original planners of Head Start debated at length whether or not the program should be evaluated. As stated by Zigler and Rescorla (1982), the main point of contention in this debate was that a program aimed at assisting poor children, giving them food, medical and social services care "should not even be questioned." They write:

> Perhaps because of this spirit, the evaluation effort which was mounted in the first summer of Head Start was poorly planned and hastely carried out. A hodgepodge of evaluation instruments culled from the literature was sent out to the many Head Start centers across the country. This created a strong negative reaction among Head Start staff and participating families, who felt that the merits of the program was obvious (p. 4).

However, Head Start did survive the pressure regarding the need to evaluate the program and became highly regarded by the media as a worthwhile social program. It became established as a national social program the following year, with approximately 400 million dollars allocated for program activities. Nevertheless, the initial problems and doubts about the program which revolved around the exaggerated and unrealistic expectations set for the program, would not disappear and later came back to haunt Head Start. As Zigler and Rescorla (1982) assert, "In essence, the program was oversold; the early enthusiasts suggested that a brief exposure to Head Start would make disadvantaged children future tax-paying citizens, that such children would be home free (p. 5)."

The overselling of the program and the unrealistic expectations were further verified in the Westinghouse Study of 1969 (Westinghouse Learning Corporation/Ohio University, 1969) which found that Head Start had no effect on the children three years after they had completed the program. This finding created a negative view of Head Start within the public and significant pressure was created to eliminate the program. The negative impact of this report on

Head Start policy was so intense that Edward Zigler's first job on taking over Head Start in 1970 was to fight to keep the program alive. Zigler argued that the main reason to maintain Head Start was the fact most social scientists found the Westinghouse Study methodology and findings questionable.

One of the main weaknesses of the Westinghouse Study, for example, was its overemphasis on cognitive development alone. Bronfenbrenner (1979c) writes:

> The members of the official research committee were opposed to the design of the Westinghouse Study. The proposed design was an overly mechanical and mindless plan for massive computer analysis of data regarding changes in intellectual development of Head Start children, obtained for noncomparable program conditions. The most predictable result of the proposed analysis, given this particular design, which left many significant variables uncontrolled, would be the finding of no differences, whether or not differences in fact existed. Moreover, this evaluation was based upon the results of objective measures primarily restricted to the domain of cognitive development without regard to other goals of Head Start in the areas of health, motivation, and social development. Nor was any attention being paid to the children's parents or the communities in which the parents lived, in our view all equally important targets of the program (p. 87).

In 1974 the Head Start program was still on a "tentative footing." The notion of "fade out" had become a dominant idea among social scientists and the media. Evaluations had found the initial gains made by Head Start children did not prevail after three or four years. Nevertheless, Bronfenbrenner (1974) and Ryan (1974) found the success of early intervention efforts relied on two factors: 1) involving parents in the training of their children and 2) public schools following the lead of Head Start by developing more compensatory programs.

Therefore, from 1975 to 1978, Head Start again declined immensely in the public view, to the point that the New York Times reported the program as having been terminated. According to Zigler and Rescorla (1982) "Public attention was now focused on Sesame Street as the new agent of socialization for the disadvantaged (p. 7)." During this time researchers were also waiting for the Consortium for Longitudinal Studies (1983) which would synthesize the mass of the longitudinal accumulative data on early intervention programs including Head Start. When the data was released, it showed substantial gains for Head Start children. The public view of Head Start then took a very positive view again. Zigler and Rescorla (1982) wrote: "Public opinion about Head Start has gone from euphoria to pessimism and back to euphoria in the past 15 years. However, the basic Head Start program has changed very little; what has changed and shifted dramatically is public attitudes about the program (p. 7)."

In summary, one could say that program evaluations in Head Start have been controversial and confusing, yet very powerful in terms of public support and government fundings. These controversial and confusing ideas can be attributed to the fact that even the original planners of Head Start were not clear about what the most important goals of Head Start should be. As stated in the literature, Head Start was initiated at a time of great ideas about how to eliminate poverty in America and improve society. Head Start was designed to help poor children, to prepare them for school, give them medical care, provide intellectual stimulation and to socialize them into community life. In addition, the original planners also wanted to improve the community by providing employment and by involving parents in the education of their children. However, these goals were never clearly set; the planners did not have a program for carrying out these enormous goals. Zigler and Rescorla (1982) stated, "no clear priorities were set, making it unclear which goals were primary and which were secondary. Failure to make the goals of Head Start clear at the onset led to many negative consequences (p. 8)."

As stated by Zigler and Farber (1984), social competence has grown as a major construct in the field of mental health in the last decade. Since then social competence has taken on a variety of meanings across practically all fields of social sciences. However, according to Zigler and Trickett (1978) social competence is frequently used without a clear understanding of its definition.

> When social scientists, public officials, and other discuss social competence, both speaker and listener have the impression that something meaningful is being transmitted. But what exactly is social competence? The construct seems to evaporate when the heat of even minimal debate is applied. Unfortunately, it appears to be one of those constructs whose own definitions are vague. Social competence theorists thus quickly find themselves adrift on a sea of words (p. 288).

Nevertheless, Zigler and Farber (1984) suggest social competence in children should first mirror the success in meeting age-appropriate social expectations. They have concluded these expectations would encompass developmental skills, social-interpersonal competencies, daily living skills, and achievements in the control of behavior and the regulation of feelings. In addition, they stated social competence should include a child's self-actualization, about his or her feeling good as a person, feeling motivated to try new experiences and feeling confident about taking new challenges. This view of the child as a whole being is clearly stated in section 1304.1-3 of the Head Start Program Performance Standards (1975):

> The overall goal of the Head Start program is to bring about a greater degree of social competence in children of low income families. By social competence is meant the child's everyday effectiveness in dealing with both present environment and later

> responsibilities in school and life. Social competence takes into account the interrelatedness of cognitive and intellectual development, physical and mental health, nutritional needs, and other factors that enable a developmental approach to helping children achieve social competence. To the accomplishment of this goal, Head Start objectives and performance standards provide for: (1) the improvement of the child's health and physical abilities, including appropriate steps to correct present physical and mental problems and to enhance every child's access to an adequate diet. The improvement of the family's attitude toward future health care and physical abilities, (2) the encouragement of self-confidence, spontaneity, curiosity, and self-discipline which will assist in the development of the child's social and emotional health, (3) the enhancement of the child's mental processes and skill with particular attention to conceptual and communication skills, (4) the establishment of patterns and expectations of success for the child, which will create a climate of confidence for present and future learning efforts and overall development, (5) an increase in the ability of the child and the family to relate to each other and to others, and (6) the enhancement of the sense of dignity and self-worth within the child and his family.

The goal of the initial Head Start planners was not to boost I.Q. by ten points but rather to enhance the everyday social competence of disadvantaged children. The goal was to foster physical well-being and social and emotional adjustment, to kindle motivation for learning, and to bolster self-esteem. The unstated hypothesis was that disadvantaged children of normal intelligence who received this early experience designed to foster social competence would have the skills and motivation to be successful in later life (Zigler and Rescorla, 1982).

I.Q. Measures as Opposed to Social Competence

In reviewing the literature on I.Q. measures in early childhood intervention programs, the authors found that in the early 1960's, prior to the beginning of Head Start, the field of early intervention programs was greatly influenced by an extensive amount of research which indicated intelligence quotients could be dramatically increased with minimal effort

(Zigler and Rescorla, 1982). In this regard I.Q. tests became central to the evaluation of early childhoood intervention programs, including Head Start and is still predominant today. I.Q. is the most frequently used evaluation measure of early intervention programs, and has been the most dominant outcome measure in the evaluation studies of Head Start (Zigler and Farber, 1984).

But why have I.Q. measures prevailed over social competence measures? One of the most frequent justifications claims I.Q. has been a strong concept in psychology and related fields since the psychometric properties of standard I.Q. tests are well documented and the fact that I.Q. tests possess a broader collection of correlates which are predictive of success. More so than any outcome measure, the debate over its usefulness and concrete results have become a tough battle (Zigler and Farber, 1984). The question then is not whether I.Q. tests are concrete and useful, but why I.Q. tests, which primarily measure cognitive ability, have consistently been the only measure to evaluate Head Start. It should be kept in mind the goal of Head Start is the promotion of social competence which views the child as a whole being and stresses the interconnectedness between the person and the environment. I.Q. measures only evaluate a small aspect of this interconnectedness. It does not reflect, for instance, motivational factors which influence test performance.

Another very significant reason why I.Q. tests have become so popular as outcome measures used to evalute Head Start is because they are easy to administer, simple to compute and relatively inexpensive. In addition, I.Q. tests are considered good predictors of school performance and this provides a good reason for utilizing such measures for assessment criterion. However, even though the correlation between I.Q. and school performance has been proven to be relatively high (.70), this high correlation only accounts for approximately half the variance in school achievement (Zigler and Rescorla, 1982). In addition to intellectual ability, personality and motivational factors such as achievement motivation, persistence and emotional adjustment also influence school success. Related to this point, school achievement and intelligence are only minimally related to successful adjustment in later life (cf. McLelland, 1973). Given these facts, the implicit goal of Head Start was to help children become well-adjusted and productive adult citizens, not to provide training to help them obtain B grades rather than C grades in elementary school (Zigler and Farber, 1984:6).

In addition to all the significant points regarding the popularity of the use of I.Q. as an outcome measure, social competence measures have not been explored as an outcome evaluation for Head Start to evaluate the effectiveness of the social competence goal. I.Q. scores, afterall, have been shown to be related to later school achievement and not the other way around. Finally, high test scores may be misleading because teaching the content of most intelligence or achievement tests may have little effect on intellectual development (Kohlberg, 1968).

A Working Definition of Social Competence

Even though social competence has been regarded by social scientists in the field of mental health as a major construct it still remains an abstract concept. For one, social competence has taken a variety of meanings across the social sciences. Zigler and Rescorla (1982) write:

> Social competence seems to be an idea whose time has come, yet there is little consensus as to what social competence is and less agreement on how best to measure it. A major point of difference is whether social competence should be broad or narrow in definition--whether the term "social" should be

> construed in its narrow sense of "interpersonal" (e.g., social interaction, social skills, etc.). A second issue concerns the relationship between social competence and "competence" in the sense introduced by White (1959). As Garmezy (Garmezy, Masten, Fordstrom & Ferrarese, 1979) has implied, social competence is a field with an enormous literature but little centrality of focus (p. 17).

In a study on the public conceptions of socially competent children and adults, Ford and Miura (1983) have suggested the existence of "shared cultural meanings" for the concept of social competence people learn at a "fairly early age." But recent research in the field of social sciences continue to indicate that despite this "shared cultural understanding" of social competence, the construct continues to be a broad term used without a clear and widely accepted definition.

Zigler and Farber (1982) claim social competence falls into two basic categories for definition: molecular and molar definitions. They have defined molecular as a concept covering specific skills an individual possesses and molar as a concept adopting a broad integrative approach to training. They write:

> Greenspan (1979) defined social intelligence or social competence as a person's ability to understand and to deal effectively with social and interpersonal objects and events. He generated a taxonomy of social competence which encompasses a variety of skills. These skills are mostly social cognitive in nature, such as role-taking, social inference and referential communication, rather than behavioral indicators of actual functioning (p. 2).

Added to this is the development of scales in order to measure social competence. They thus conclude:

> In summary, while there are a number of scales or procedures which are intended to measure social competence, there are none which we consider appropriate for the task we outlined above; that is evaluating intervention programs. Some of the existing instruments define social competence too narrowly. Many of the scales currently available are

> oriented toward the detection of pathology rather than directly addressing issues of competence and adaption. The scales of this type tend to be useful for differentiating normal children from children with problems but they ignore individual differences in competence among the heterogenous group of normal children. Another limitation of existing instruments is that they are often geared to one specific period of life (e.g. the preschool years). Finally, most scales are too lengthy and complex to be applied in large-scale use (p. 9-10).

Having briefly reviewed the literature on social competence, the main struggle for the authors of this study was to find a definition of social competence which would encompass the MHP/IP ecological approach of viewing the child as a whole being integrated in the framework of the family from which the child receives his/her primary needs. In this regard, Zigler and Farber's (1982) definition of social competence best summarized the direction of the MHP/IP. They have written:

> Social competence in children must first reflect the individual's success in meeting age-appropriate societal expectations. These expectations include developmental skills, social-interpersonal competencies, daily-living skills, and achievement in control of behavior and regulation of feelings. Secondly, we feel that the notion of social competence should encompass something about a child's self-actualization, about his or her feeling good as a person, feeling motivated to try new experiences and confident about tackling new challenges (p. 10).

MHP/IP Emphasis on Social Competence

An important effort of the MHP/IP was to define social competence and develop measures to assess the social competence of children and families. Some factors related to social competence included a sense of self-esteem, individual responsibility, personal integrity, creativity, interdependence, an individual's everyday effectiveness in dealing with his/her environment, and a concern for the whole. In addition, social competence, for the purposes of this study, was defined as the ability of the child and family to adapt functionally through the acquisition of new skills for living.

It was also the goal of the MHP/IP to promote social competence of parents by supporting them as the primary educators of their children. Their inherent strengths and the value of their culture, not their deficits, were the basis for the interconnectedness between the parent, the teacher and, when mental health service was necessary, the counselor, thus emphasizing a team approach. By involving parents in all aspects of the Head Start experience of their children, they were more likely to develop a positive attitude toward the program, the community at large, and themselves as parents.

The MHP/IP goal for social competence was to strengthen child, parent, and family self-esteem, individual responsibility, personal integrity, creativity, interdependence, and an individual's everyday effectiveness in dealing with the environment and a concern for the whole. This was promoted by strengthening the family's life and supporting the relationship between the child, the family, the Head Start program and the community. In addition, the second aspect of social competence, the ability of the child and the family to adapt functionally through the acquisition of new skills, was also emphasized. By reducing the psychological dysfunction in children and families who were referred to the mental health component, the authors believed these families would be able to function more adaptively and learn effective problem solving skills. The early identification and treatment of high risk factors, which have the potential to cause long range damaging effects, were believed to allow parents to better interact and respect one another, know the importance of their role in the family, and support their children in their everyday lives. In promoting social competence, which was partially assessed through the reduction of psychological dysfunction (i.e., high risk), the authors' wanted to use a pre and post test and a social competence index to measure the reduction of high risk. However, because of the brevity of this study, this goal was not accomplished and, as a result, the authors' will do a continued analysis in this area at a future date.

The MHP/IP emphasis on the ecological approach of social competence and human development went beyond the deficit model which according to Ryan (1976) are vehicles for "blaming the victim." As stated in chapter one, deficit models pervade every aspect of our society, especially in the human service field where in order to receive help one must qualify by proving one's condition warrants such assistance. The affect of such policies have taken "a substantial toll on the individual's self-esteem and the family's capacity to function (Bronfenbrenner and Weiss, 1983:396)."

As it has been shown throughout this chapter, the MHP/IP position on social competence has its origins in the work of Edward Zigler, who has over the years stressed the need to use social competence as an evaluation outcome in Head Start, instead of the cognitive approach emphasizing higher I.Q. as an outcome measure. However, the abstract view of such a concept and a lack of consensus among social scientists in how to use the term, still leaves the issue unresolved. Zigler and Rescorla (1982), have proposed a children's social competence scale. Such a scale is in the process of being piloted with a sample of 500 children and as stated in their paper, the scale assesses domains, grouped into 4 major spheres of development: (1) developmental skills, (2) social-interpersonal skills, (3) emotional-personal skills and (4) health. Their scale provides for a mixture of developmental items and factors considered to be significant components for the development of social competence at any age. By rating the completed scales, evaluators will be able to indicate whether the child is developing at the expected pace for his or her age. In sum, many experts in the field of early childhood intervention programs, including some of the original planners of Head Start, have argued the importance of social competence measures to evalute the impact of Head Start, not only for Head Start children and families, but also as a proven, valid, and clearly defined measure to evaluate programs aimed at the community at large.

Chapter 4

CONCEPTUAL FRAMEWORK

Overview

Recognizing the importance of social environments and their development as ideal settings for social intervention, researchers such as Bronfenbrenner (1984) have suggested the necessity of understanding behavior within its natural environment. Social intervention as a strategy suggested by community psychologists implies that with the creation of alternative or improved social structures, the quality of fit between the person and their environment can be maximized. This socio-ecological dependence of systems requires that a broader view of mental health needs and services be used which recognize the children, families, and the community of Head Start. The families of Head Start in this way are identified and supported as a total unit or ecosystem of interdependent functions and responsibilities. In the context of Head Start, the purpose of these supportive systems is to improve the opportunities for education and services. This chapter presents a theoretical discussion on the nature of socio-ecological systems and their relation to the MHP/IP.

Education and Social Structure

Education as a social institution in our society provides the social structure for learning and group social development. The functions of most social structures are to: 1) cycle resources, 2) aid in adaptation, and 3) provide a process of orderly change. Education, as an example, provides the means of assuring the continuance of current knowledge. By definition, a Head Start enrollee is presumed to require or benefit from a "head start" in learning. The transfer of skills and the dissemination of knowledge has been recognized and can be conditioned, directed and integrated at a much earlier school age then kindergarten.

Yet, the same recognition that social values, emotional conditions and a general feeling of well being can also be acquired at three years of age has not been forthcoming. For example, mental health services have always been paradoxically required as a part of Head Start policy. Yet in the last twenty years of Head Start research, not a single study has been conducted to test or evaluate a fully implemented mental health services program or component. One study which focused on a training and consultation model and not direct services to children and families, lost funding in the third year of operation, and as a result, no relevent data is available. The MHP/IP is the first study which presents findings related to treatment outcomes of mental health services provided directly through a mental health services component of a Head Start agency.

A Socio-Ecological Approach

The socio-ecological context of research and data analysis required that a multidimensional model of data collection be used. Data collected on the child alone, for example, would only be used in a vacuum if it were not to include the observations of the family in the home. The impressions of the teacher, parent and mental health classroom counselor were considered to be of equal importance in this analysis. Both needs assessment and follow-up assessment were conducted on all or part of the sample. Follow up was also conducted on those families receiving mental health services.

The selection of consultation strategies of intervention in addition to strategies of psychotherapy, were done to address another major concern of this socioecological approach. It has long been recognized (Rappaport, 1977) that the ecological dimensions of the environment influence the potential for health growth and the prevention of mental disability. These six dimensions are: 1) the ecological dimensions; 2) organizational structure; 3) personal characteristics; 4) behavior settings; 5) reinforcement of environment; and 6) psychosocial characteristics and organizational climate.

The consultation strategies of the mental health services component were directed at providing teachers with skills and information relevant to the family, the child, and to their own interactions with the child in the classroom. As the quality of the interactions improved between the teaching staff, family and child, so too did the quality and potential for growth and development. Kelly (1983) addresses this issue in the consultative process in which the role of the consultant is to identify resources as well as mobilizing those resources for future use. He illustrates this point by focusing on teachers:

> The competence of a classroom teacher, for example, to manage and direct a child who is at the moment nonachieving can be enhanced when both the consultant and the consultee work out the solution by drawing upon the help of other children, other teachers, parents, and staff such as custodians, secretaries, and teachers' aides. The ecological point of view asserts that prevention of a person's health problem is achieved by involving available resources not now related to this particular topic and by identifying potential resources for the future (p. 150).

The strategies of family psychotherapy were directed to impact more specific problems identified as a result of the observation and information gathered in the assessment phase of the mental health intervention. This intervention was selected for its flexibility of approach and its opportunity for long range success. The focus from the individual to familial systems allowed for the intervention to be directed on a case by case basis. In many instances, individual problems became identified as family concerns. For example, the intervention into the family was based on the multiple levels of information received and determination to seek out the family for therapy. Factors such as an individual's sense of self-esteem, self-confidence, and a sense of competence begin to emerge as central issues related to a sense of belonging or fit. If a child does not feel capable, or is fearful, or lacks in particular social or verbal skills, then the potential for maladjustment may be greater. If, on the other hand, a child can become aware of his/her strengths, experiment with taking risks in new social settings, and gain confidence in one's own ability towards success, the potential for growth and personal self-esteem are enhanced. By implication, as problems or concerns of the family become resolved, the child gains greater confidence in his or her own abilities for learning.

In some of the most debilitary situations of the household, it is clearly known the impact of a disruptive home will no doubt affect the children's potential for personal success. Personal success has many translations, particularly in the field of education. In this study the issue of social competence became one measure of success which was also described through the socio-ecological perspective. This report demonstrates findings of a 14 month study designed to assess the impact and effectiveness of mental health services delivered to "high risk" children and families of Head Start.

Data indicates that 78% of the families were Hispanic, 54% were monolingual Spanish speaking and 96% were below the poverty level, averaging $500-600 a month in income. Mental Health services to this high risk Head Start population were measured through outcome measures which included: a) reduction in family dysfunction, b) resolution of precipitating crisis, and c) increased family competence.

For the purpose of this study high risk was defined from an external and an internal perspective. In order to give a broad definition of the term, on an external level some of the factors that contributed to high risk were poverty, chronic unemployment, lack of education, and other social-economic variables. Low income families lend themselves to a high incidence of psychpathology, school drop-outs, juvenile delinquency, incarcerations and drug and alcohol abuse than the general population; low income families and their children experience more stress and therefore, a greater potential for high risk in health and mental health disorders than the general population of preschool age children and their families. The President's Commission on Mental Health (1978) indicates extensive evidence has led to the conclusion poverty increases the risk for serious psychiatric and developmental disturbances. Almost any disorder is more likely to occur with a high risk population at a rate several times greater than with the mainstream population.

Social competence was assessed from the perspective of the types of individual responsibilities which were influential in the family's effectiveness in dealing with everyday life. Some factors that we viewed as part of social competence included a sense of self-esteem, individual responsibility, personal integrity, creativity, interdependence, and an individual's everyday effectiveness in dealing with his/her environment, and a concern for the whole. In addition, social competence, for the purpose of this study, was defined as the ability of the child and family to adapt functionally through the acquisition of new social skills for living. Social competence was used as an indicator of social integration. Social integration was especially important in encouraging the utilization of services intended to improve the future quality of life for these families.

On an internal level, there are other factors which contribute to high risk for emotional abuse and neglect. According to the federally funded National Incidence Study (Burgdorff, 1980) the definitions of emotional abuse included: verbal or emotional assault, close confinement and threatened harm. The definition of emotional neglect included: inadequate nurturance/affection; knowingly permitting maladaptive behavior (e.g., delinquency), other refusal to provide essential care. In addition, other factors related to high risk include: lack of parenting skills; a parent(s) individual unresolved issues; divorce, separation, marital problems, familial systemic dysfunctional communication, domestic violence, child abuse and coping with loss/death.

Three intervention strategies were tested: 1) staff training and consultation, 2) parent education and involvement, and 3) in-house mental health treatment services including short term psychotherapy. Outcome evaluations were used to assess the impact of these interventions on a selected group of Head Start children and families.

One intended goal of the MHP/IP was the development of a needs assessment with the potential to identify high risk factors in Head Start families. Early identification of risk and the ability to follow-up through prevention and treatment intervention offered the potential for psychological impact at the earliest stage possible. The first stage in obtaining data on children and families was through the implementation of a needs assessment and social competence survey. The survey was designed to provide information regarding the needs, social history, and special circumstances impacting on the child and family. Information regarding problems of high risk and the service utilization of human services provided an understanding of the systems about which families were aware. In addition, family problems and issues regarding an individual's desire for counseling or assistance, for the child or family, were identified (see chapters 6 and 7). Finally, a follow-up assessment, a modified version of the needs assessment was conducted with 220 respondents. In addition, for future analysis, the outcome of treatment can be compared to the needs assessment and follow-up assessment (see Chart 1). The goal of this analysis was to present a profile for the reduction of high risk and its impact on the ability to help and treat problems as early as they are identified.

The second stage of analysis involved a comparison of the respondents needs (845) as identified in the needs assessment and factors associated to high risk. These high risk factors included: 1) the need for information about a problem, 2) the availability of family social support networks, 3) the availability of a pre-paid health plan, and 4) health or social problems of the child reported by parents. The factors described indicated a sense of adaptation and stability as a community resident.

In the final stage of analysis, a comparison of treatment outcomes on families and children (121) seen for psychological counseling is presented. This treatment analysis was designed to measure the effectiveness and impact of mental health prevention and treatment services with the children and family served by the mental health component of Head Start. Classroom observations, case documentation, case review methods and procedures were combined to represent the ecological perspective of social interventions in mental health services (see chapters 8, 9, and 10).

Chart 1

MHP/IP Chart of Analysis

Independent Variables

1. Family Needs Assessment (845 Families)
    - A. Family Needs
    - B. Social History
    - C. Issues Impacting on Family
    - D. Problems of High Risk
    - E. Service Utilization
2. Social Competency Survey

Mediating Variables

1. Demographic Characteristics
    - A. Income
    - B. Education
    - C. Occupation
2. Identified High - Medium - and Low Risk Factors
    - A. Need for information
    - B. Availability of family social support networks
    - C. Availability of a pre-paid health plan
    - D. Health or social problems of child

Dependent Variables

1. Staff Training and Consultation
2. Parent Education and Involvement
3. Treatment Outcomes (199 children and families)
    - A. Type of treatment
    - B. Resolution of Presenting Problem
    - C. Length of time in Treatment
    - D. Counselor, teacher, and parent assessment

Chapter 5

RESEARCH DESIGN AND METHODOLOGY

Overview

This 14 month demonstration and research project was designed as an outcome evaluation study to assess the effectiveness and impact of mental health prevention and intervention services to a high risk population. The unique elements of the setting required a multiple measure approach be used in the data collection and analysis of these Head Start families and children. Because of diverse needs within the population and the effects of treatment, an analysis was required which included a series of multiple sampling methods, instruments directed at the measures of group and organizational intervention, and an analysis of post-treatment outcomes. The sections of this chapter are presented under the headings of the setting, sampling instrumentation, procedures and project procedures.

The Setting

The Latin American Civic Association (LACA) was organized as a non-profit organization in June, 1965. Since that time, LACA has been a major provider of community-based programs to low income families in the San Fernando Valley located in Los Angeles County. The basic mission of the organization is to improve the socio-economic status of residents of the community as well as stimulate development of human and economic resources within the community itself. By mobilizing public and private resources, LACA is able to provide economic, social and educational development within the community.

The largest program within the structure of LACA has been two government-funded preschool programs: Head Start and the California State

Preschool. LACA is in fact one of the two largest Head Start delegate agencies in the state of California. The staff of 192 persons deliver over $2.5 million dollars annually in services to low-income and special needs children and their families. The MHP/IP project was located in this facility where three therapy rooms, one specialized play therapy room, two observation rooms for the purpose of training, and office space for the mental health specialist and counselors were provided.

Within the LACA Head Start Program there are 23 sites, with 64 classrooms, dispersed throughout the San Fernando Valley and the Santa Clarita Valley. Each classroom enrolls 16 children and is staffed by one teacher and one teaching assistant. On a daily basis, 960 children from all ethnic groups, participate in their first educational experience at LACA and receive important support services including health, mental health, nutrition, social services, handicap and parent involvement. 10% of the children are handicapped and receive additional educational or therapeutic assistance. Data gathered on families within the past year provides the following information: 77% are Hispanic; other ethnic groups include, Caucasian (13.3%), Black (6.3%), and Asian (1.8%). With the large Hispanic population, 53.3% of the children speak only Spanish when they enter school; 16.6% are bilingual English/Spanish. As a result, LACA's program provides essential multicultural and bilingual components. The majority (54.7%) of the families are "traditional:" that is, two parents are present with only one employed. The next highest group or 22.1%, has only one parent in the home, with that person unemployed. Although Head Start permits the enrollment of 10% of children above the income criteria, 96.3% of the children live below the poverty level criteria.

El Centro de Amistad, Inc. is a community based human services organization located in the West San Fernando Valley. Program development, research and program evaluation are components of El Centro's services. The focus of research is based on a cultural model of service delivery and treatment. The coordination of this research effort represents the willingness to provide services through systems that best meet the need of low-income Latino families. El Centro de Amistad's research component was contracted by LACA to develop and complete the collection and analysis of data. The Los Angeles County Department of Mental Health supports El Centro through a yearly contract. Service includes crisis counseling, outreach services, case and program consultation, information and referral, and legal and court advocacy. In the past year, over 3,000 individuals and organizations receive services from this center.

Sampling

The target population for this study were the 960 families who participated in the Head Start program during the 1984-1985 school year. Data from three sample populations are presented based upon the needs assessment, follow-up assessment and reported treatment outcomes. Every family had the potential to participate in the needs assessment and all 64 sites were represented in the analysis of the findings. Of the 960 families contacted, 845 surveys were completed and returned.

Family information was designed to provide basic information on the family, such as the type of residence, number of adults and children in the household, whether or not families had friends or family members within the community which act as support systems. Information on the child was elicited from parents on the child's care outside the home. The section on family issues asked questions regarding the parent's feelings towards themselves such as life satisfaction, problems which present themselves on a daily basis and the child's reaction to family disagreements. Lastly, the researchers wanted to know the degree to which parents utilized human services, their knowledge of specific agencies, and what type of information or services they needed at the present time.

The follow-up assessment surveyed a sample of 220 families. Site selection for the follow-up assessment was based on the sites reporting a higher incidence of referrals to the mental health component. All families and children had the potential to be identified as requiring services. Teacher referral, parent referral, or support staff served as the three primary referral sources. 199 mental health referrals were made.

Instrumentation

Eight instruments were used for the purpose of analysis. The intent of these instruments was to provide a systematic outcome analysis of the amount and type of social need, and the level of social competence. Outcome measures related to staff training and consultation and mental health services delivered provided information to be used to assess the impact of these services. These instruments include: 1) Family Needs Assessment and the Follow-up Assessment; 2) Family Social Competence Survey; 3) Mental Health Classroom Observation/Supervision Cycle; 4) Teacher Feedback on the Mental Health Observation/Supervision Cycle; 5) Mental Health Individual Child Observation/Action Plan; 6) MHP/IP Parent Evaluation of Mental Health; 7) Mental Health Intake Form; and 8) Mental Health Summary Form (see Appendix 1).

Family Needs Assessment and Follow-up Assessment

The needs assessment was designed to elicit information on the needs, problems, and status of the family and child participating in Head Start. The research team constructed the instrument to reflect four areas of concern to Head Start. These areas were selected on the basis of identifying families at risk. The areas addressed were 1) family information, 2) the needs of the child, 3) family issues and needs, and 4) service utilization.

Family Social Competence Survey

The central purpose of the Family Social Competence Survey was to represent the socio-ecological perspective of competence among lower-socioeconomic families. For example, the ability to provide a self sufficient household based on the limited resources available is indicative of competence in the management of one's own resources. Examples of areas of competence which were explored included: bicultural ability, ability to meet basic needs (food and shelter for family functioning), support for community needs, attitudes toward education of one's children. This last sample was perhaps the most important for it demonstrates that parents, regardless of economic status are concerned for their children's education.

Mental Health Classroom Observation Cycle

The mental health counselor and the Child Development Specialist (CDS) did a joint observation/supervision cycle. This cycle was a four hour classroom observation conducted in all 64 classrooms, followed by a two hour training and consultation session with the teaching staff.

Teacher Feedback on the Mental Health Observation Form

This form was completed by the teacher and concerned the effectiveness of the mental health interventions. Questions related to the teacher/child interactions, child's behavior changes, and overall assessment of the value of the mental health staff consultation effort were included.

Mental Health Individual Child Observation Plan

Each child referred for mental health services was observed for 2-4 hours by the mental health staff. Observations of the child's behavior, emotional affect, and interactions with peers and teachers was recorded on this form. An Action Plan was recorded giving recommendations for helping the child to adjust, both emotionally and behaviorally to the classroom environment.

MHP/IP Parent Evaluation of Mental Health

This instrument was used by mental health counselors in order to have parents evaluate mental health services. The parents gave permission for a counselor, other than the one assigned to their case, to contact them. This was to help the parents to feel comfortable to honestly respond to the questions. Parents were asked to respond to the following questions: was treatment provided by the mental health component helpful; what helped you the most in counseling; what were those things least liked about mental health services; and suggestions for improving services.

Mental Health Intake Form

This form was developed for use by the mental health component and provided basis demographic data such as age, birthdate, marital status, and ethnic background. In addition, data was provided on employment history for both parents. If parents were unemployed, their source of income, i.e. from public sources, for example, were recorded. Data was also collected on educational history. With regards to the child, data gathered on reason for being referred and the presenting problems, recorded in the referral, was included in the document.

Mental Health Case Summary Form

This instrument served as a complete record of the treatment services received by the client from the mental health component. It covered number of sessions, data on parents, presenting problem before assessment (from referral) and problem after assessment, treatment goals and final review. The final review is conducted eight weeks after the case has been closed.

Procedures

1. Staff Training and Consultation

Goals

The goals for staff training and consultation were: (1) to orient the staff to the implementation of the MHP/IP for the purpose of understanding and supporting the project, knowing their role, and understanding the staff training and consultation process, procedures for referrals, and procedures for mental health services; (2) facilitate their staff's positive attitude toward mental health services; (3) promote early identification of children with problems and prompt referral to mental health and or appropriate components; (4) provide direct training to teaching staff in the area of promoting an emotionally supportive environment in the classroom; and (5) to provide training to teaching staff in the areas of child growth and development, observation techniques, effective communication, behavior management, and strategies for dealing with specific child behaviors.

Objectives

The objectives for the staff training and consultation were: (1) to increase the utilization of mental health services measured by an increase in the number of referrals received by the mental health component (measured by the number of referrals); (2) to reduce child psychological dysfunction by training the teaching staff on the uses of effective behavior and emotional classroom management skills (measured by Mental Health Individual Child Observation/Action Plan and 8 week review); and (3) to increase the teaching staff's confidence in their abilities to handle their classrooms (measured by teachers feedback to cycles).

Procedures

The following were procedures used for staff training and consultation: (1) MHP/IP staff orientation; (2) Mental Health Classroom Observation/Supervision Cycle; (3) Mental Health Individual Child Observation/ Action Plan; and (4) Staff Evaluation of Mental health services.

MHP/IP Staff Orientation: As stated in the goals of staff training and consultation, all LACA staff were oriented to the implementation of the MHP/IP for the purpose of understanding and supporting the project, knowing their roles, understanding the staff training and consultation process, understanding procedures for referrals and mental health services, and fostering a positive attitude towards mental health. The object of such training was to increase the utilization of mental health services measured increase the number of referrals received by the mental health component. This orientation occurred in the first month of the program, September 1984, by the mental health staff. All of LACA's 180 teaching and component staff were divided into 6 groups and each group received a 30 minute orientation.

Mental Health Classroom Observation/Supervision: The Head Start mental health components of Los Angeles County are required to observe all children enrolled in the program through what is called an observation cycle. The educational component is required to observe the teaching staff and this procedure is referred to as a supervision cycle. In the MHP/IP the Child

Development Specialist (CDS) and the mental health counselor do a joint observation conducted in all 64 classrooms, followed by a 2-hour training and consultation session with the teaching staff.

The result was the early identification of children with problems and prompt referral to mental health and/or appropriate components. In the feedback session following the observation, immediate direct training was given to the teaching staff in the areas of providing an emotionally supportive environment in the classroom; teacher/teacher interactions; teacher/child interactions; and appropriate language and training in handling specific behavior problems. In this way, preventive mental health concepts were integrated into the classrooms. As a result of the observation/supervision cycle, children were referred to the mental health component for services including short-term psychotherapy.

Mental Health Individual Child Observation/Action Plan: As previously mentioned in the procedures for treatment services, once a child and/or family were referred to the mental health component, the first part of the treatment services consisted of a 2 - 4 hour observation of the child. Following the observation, direct training to the teaching staff on providing an emotionally supportive environment for the child; on facilitating appropriate teacher/teacher and teacher/child interactions and providing classroom management skills, all for the purpose of supporting the child in the classroom. This information was recorded on the Mental Health Individual Child Classroom Observation/Action Plan form. The Action Plan consisted of documentation of the training and recommendations for the teacher to emotionally support the child in the classroom and effectively minimize the effects of the problem.

In addition to the three preceding staff training strategies already discussed, the mental health staff provided a minimum of 1½ hours per referral of additional training and consultation to the teaching staff. Examples included: periodic telephone calls to discuss the effectiveness of the action plan recommendations, and if necessary to plan new strategies to assist the teacher in the classroom.

Staff Evaluation of Mental Health Services: The Mental Health Classroom Observation/Supervision Cycle was evaluated by the teaching staff through the use of the Teacher Feedback-Mental Health Observation/Supervision form. In addition, the teachers also did an evaluation of the overall effectiveness of the mental health component. These findings will be discussed in Chapter 8.

2. Parent Education and Involvement

Goals

Parents bring their children to Head Start for assistance in preparing them for future participation in public education. In this process, parents are introduced to a myriad of services, committees, rules and regulations, and other structural factors which are presented as vehicles in completing their children's "head start." The MHP/IP project developed activities which would enable parents to work as partners with Head Start teachers and staff in achieving the total development of the child and family.

Objectives

The objectives of parent education and involvement activities were to provide training of parents in parenting skills and child development in order to reduce the potential for high risk. In addition, community resources would be mobilized, parent participation increased in order to provide social support and enhance coping mechanisms within Head Start families.

Procedures

There were three original procedures organized as part of the study: 1) parent education sessions; 2) monthly family nights; and 3) parent education/support staff training.

Parent education sessions were to be conducted by a parent educator (primary prevention). The sessions were scheduled at each Head Start site and there, parents would meet as a group in the parent education workshop on child development. Prior to the parent training all LACA staff (supervisory and support staff) were to be given the same training. The objective of the training was to introduce all staff to the quality and content of the Head Start program. The expected outcomes would be broad parent participation in the training supported and encouraged by all staff.

Monthly family nights provided a forum for information/education/ questions on parenting for adult family members as well as supervised play activities for children. These meetings would also enable parents to voice concerns or criticisms about the Head Start program or to offer suggestions on how the program can better serve the needs of parents.

However, the intensive parent education/support staff training and parent-to-parent volunteers which were in the original proposal, were not realized for a number of reasons. The intensive training sessions were to provide comprehensive education to parents who had completed the parent education workshops. These parents were to also comprise the parent-to-parent volunteer network at selected Head Start sites. Using specially produced video tapes of parenting sessions, the networks would assist other parents in gaining a better understanding of child development; however, due to constraints in time, the hiring of the parent educator, and a lack of coordination between management and MHP/IP staff, these components of the the project were never carried out and will be discussed further in chapter 12.

3. In-House Mental Health Treatment Services

As stated in chapter two the primary goal and objective of treatment services was to provide prevention, early identification and intervention in problems that interfere with a child/or family's social and psychological development for the purpose of fostering social competence.

Goals

The goals for treatment services were (1) to strengthen family life and support parents as the primary educators of their children, (2) to promote social competence in the child and family, (3) to support relations between the child, family, Head Start program and community; and (4) to develop a positive attitude towards mental health services.

Objectives

The objectives for treatment services were: (1) To reduce psychological dysfunction in children and families that were referred to the mental component through prevention, early identification and intervention (measured by findings of case summary), (2) To increase utilization of mental health services to the mental health component (measured by the number of referrals received; 3) To switch the focus of mental health service delivery from a child-centered program to a family-centered program (measured by original presenting problem of presenting problem after assessment).

Procedures For Treatment Services

Treatment services were in two steps (1) assessment and, (2) treatment/short term psychotherapy.

1. Assessment

The following were the stages of assessment of the problem (a) mental health classroom observation/supervision cycle, (b) referrals, (c) classroom observation, and (d) parent/teacher conference.

A. Mental Health Classroom Observation/Supervision Cycle

In the MHP/IP, the CDS and the mental health counselor did a joint Mental Health Observation/Supervision cycle. This cycle was a 4 hour classroom observation conducted in all 64 classrooms, followed by a 2-hour training and consultation session with the teaching staff.

The result was the early identification of children with problems and prompt referral to mental health and/or appropriate components. In the feedback session following the observation, immediate direct training was given to teaching staff in the areas of providing an emotionally supportive environment in the classroom, teacher/teacher interactions, teacher/child interactions, and appropriate language and training in handling specific behavior problems. In this way, preventative mental health strategies were integrated into the classrooms. As a result of the observation/supervision cycles, children were referred to the MHP/IP for treatment services including short-term psychotherapy (secondary prevention) with their families. Children were also referred to the handicap component for assessment and certification where needed (tertiary prevention).

B. Referrals

The referral form was developed to refer children, their siblings, parent(s) and/or other family members to the mental health and appropriate components. Referrals were initiated by any staff person such as the teaching, mental health, educational, nursing, social services, parent involvement, nutrition and handicap staff, and or parents (Appendix 2).

Upon receiving the referral the mental health counselor to whom the case was assigned contacted the teacher and/or referring person and obtained the following information:

1. Description and duration of problem as teacher/referral source views it.
2. What has the child's family been told about the referral?
3. What does the teacher/referral source know about the family dynamics?
4. Schedule a school observation and parent/teacher conference.

Classroom Observation

Once a child and/or family was referred to the mental health component, the first part of the treatment services consisted of 2-4 hour observation of the child. The mental health classroom observation questions (see Appendix 3) addressed concerns that the mental health counselor considered when observing the child. This information was recorded on the Mental Health Individual Child Observation/Action Plan form. Following the observation, direct training was given to the teaching staff on providing an emotionally supportive environment for the child; on facilitating appropriate teacher-teacher and teacher-child interaction; and providing classroom management skills.

D. Parent-Teacher Conference

After the observation, the mental health counselor conducts what is called a parent-teacher conference at which time the parent(s), teachers, and counselor met to discuss the reason for the referral. At this time they expressed their concerns about the child and possible course of action to resolve the problem. Services offered by the mental health component and the steps were explained. An appointment for a preliminary session was set.

2. Treatment/Short-Term Psychotherapy

The following stages of treatment/short term psychotherapy: (a) preliminary; (b) screening; (c) staffing/treatment plan; (d) interpretive session; (e) continuation of treatment; (f) case closing; and (g) final review.

A. Preliminary Session:

For the purpose of the MHP/IP, treatment actually began at the preliminary session in which the history of the presenting problem was discussed with the counselor and the parents (see Appendix 4). In intact families, both parents (or parent and significant other) were encouraged to attend. The MHP/IP supported both parents and/or significant others as being critical to their children's emotional and developmental growth.

At this session confidentiality was explained and consent, release, and intake forms were signed. An appointment was then made for the screening session for the entire family.

B. Screening Session

The parents, referred child, other siblings, and any other members of the household are in this session to discuss the reason for the referral. Drawing and play activities are done by the entire family to place the family at ease and as a means of observing family dynamics. Since our focus is on the entire family, not just the referred child, the counselor asked all the children if they knew why they had come to the session. If they didn't know why they were present the parents were asked to explain the reason for the session. The counselor explained to the entire family that we have come together to talk about problems and work together in their resolution. The objective of this session was to observe overall family dynamics, parenting responsibilities, problem solving skills, limit setting, communication patterns, alliances, and reinforcement of appropriate and/or inappropriate behavior. All of this information was taken into account when formulating an appropriate treatment plan. Preliminary, screening and subsequent sessions were recorded on the progress notes. An appointment was made for the interpretive, at which time a decision was made by the parents and the counselor for the course of treatment. At this time any other information needed to further assess the problem was gathered, i.e. medical records, psychological school and social service agency reports, etc.

C. Staffing/Treatment Plan

The mental health counselor reviewed all the information and wrote up his/her clinical finding and tentative treatment plan (i.e., family, conjoint, individual and/or play therapy.) The case was staffed either at the weekly staff meeting or individually with the mental health specialist for review and approval of the treatment plan which would then be discussed at the interpretive session with the parents.

Staffing Outline

1) Basic Information

    a) Age of Child
    b) Brief description - overall impressions
    c) Referred by:
    d) Presenting problem upon application for treatment

2) Background Information:

    a) Noteworthy development deficits in child's history
    b) Pertinent medical data (e.g., neurological eval., abnormal finding from pediatrician, use of medication, results of hearing and vision tests, etc.)
    c) Education background - reports from nursery schools, day care, etc.
    d) Abnormal test results from other center or related sources
    e) Major changes in environment, family structure, significant caretakers.

3) Classroom Observation/Action Plan Parent/Teacher Conference Findings

4) Preliminary and Screening Sessions Findings

5) Description of Child:

   a) Emotional development: consider expression of affect, ability to form trusting relationships, ability to engage with others/separate from others, expression of ideas and interests, level of motivation and curiosity, interest in mastering new experiences, level of anxiety and types of attempts made to manage it, areas of pressure and satisfaction, major themes in play, repetitive themes in artwork, major defenses used, etc.

   b) Behavioral development: consider attention span, frustration, tolerance, attitudes towards failure, overall activity level, idiosyncrasies, distractability, sensitivity to noise and visual stimuli, behavior one-to-one, in age group, at transition times, on the year etc.

   c) Social development: consider level of interaction with adults and with peers, types of attempts made to engage others, quality of interactions: passive/aggressive, independent/dependent, perseverative/open ended, etc. is play imitative, parallel, interactive? Behavior when given directions, limits or help, degree of self vs. other-relatedness, what feeling does child stimulate in other children, other adults.

6) Clinical Findings:

7) Treatment Plan:

D. Interpretive Session

At the interpretive session the mental health counselor presented and explained the treatment services recommended to the parents. Parents were given an opportunity to discuss the findings, the recommendations and their decision concerning continuation of treatment. Mental health services, types of treatment, treatment goals, and the recommended length of treatment was discussed. If continued treatment was necessary and the parents agreed, then the services continued. In some cases treatment was completed by this stage. If the parents refused to continue needed treatment, then the counselor explained the implications involved in interrupting treatment. If the parents still refused to continue treatment a referral to an outside agency for future need was made. If the referred child were the Head Start child, the mental health counselor continued to work with the teacher assisting him/her with classroom behavior management and emotional issues.

E. Continuation of Treatment

Treatment services included one or a combination of the following: (1) family, (2) conjoint, (3) play, and/or (4) individual adult therapy. Treatment continued until the problems were resolved or the client terminated serves at which time the case was closed.

F. Case Closing

G. Final Review

A review of the case occurred 8 weeks after the case was closed. This procedure included the counselor first contacting the teacher to discuss how the child and family were coping with the problem. If the client was an adult, the counselor directly contacted that person.

If the teacher was in need of further assistance in the classroom, the counselor arranged for another classroom observation and further assistance was given to the teacher to assist and support the child in the classroom.

Chapter 6

NEEDS ASSESSMENT

Overview

The needs assessment was designed to elicit information on the needs, problems, and status of the child and family participating in Head Start. These areas were selected on the basis of identifying families at risk and addressed: 1) family information; 2) the child; 3) family issues; and 4) service utilization.

Family information was designed to provide data such as the type of residence, number of adults and children in the household and whether or not families had friends or family members within the community acting as support systems. Information was elicited from parents on the child's overall health, sleeping and eating habits, and child care outside the home. The section on family issues asked questions regarding the parent's feelings towards themselves such as life satisfaction, problems which present themselves on a daily basis and the child's reaction to family disagreements. Lastly, researchers wanted to know the degree parents utilized human services, their knowledge of specific agencies, and what type of information or services they felt were needed at the time of the study.

The instrument was implemented in two parts. The needs assessment was scheduled to be administered in early September when the Head Start program began. However, it was not until the first week in October that implementation of the instrument took place because the grant itself was not received until late September instead of July. A pretest was organized with parents from one Head Start site. Researchers interviewed 10 parents to determine problems related to the question of language and the instrument itself. Parents were also given the opportunity to comment on the instrument, its strengths and weaknesses.

The completed instrument was administered in both English and Spanish which reflected the language preference of the parents in the program. Yet, the researchers did not anticipate other language groups being present in the study population. As a result, 24 families did not answer the needs assessment because they spoke only Cambodian or Vietnamese. Attempts to locate translators who could interview parents in their respective languages were unsuccessful. As a result, these parents were not included in the study.

The instrument was administered by teachers at each Head Start site. It was suggested the instrument be administered during a home visit or by arrangement at the school site. One week before the implementation of the instrument a half-day long training session was held with teachers in order to familiarize them with the instrument. One problem faced by the research team involved a few teachers who resisted having to implement the instrument. The argument was that they were never asked if they wanted to participate in the study, but in fact, had the work "dumped" on them. This stemmed in large part from the workload teachers were already carrying. Yet, in spite of these problems, most teachers were supportive and did a good job in reaching the parents. The needs assessment was administered to 960 parents but after returns were checked it was found some assessments were either not returned, or not completed because of language, and others still were incomplete because parents could not be reached at a desirable time, leaving a total of 845 completed assessments. The remaining sections of this chapter will address the findings of the assessment related to: 1) Demographics, 2) Needs Assessment Identification, 3) Indicators of High Risk, and 4) Follow-up Assessment.

Demographics of Population

During the 1984-85 school year, LACA's total enrollment totalled 1,184 students who were registered in the Head Start program. The ethnic background of the population broke down as follows:

Mexican/Mexican Americans	846	70.3%
Caucasian	122	10.1
Hispanic (other)	78	6.8
Black	79	6.6
Other	59	3.8
	1,184	100.0%

It should be noted that throughout the course of the year various students dropped the program and those children on the waiting list were then registered. Thus, the above figure represents the total enrollment for the school year.

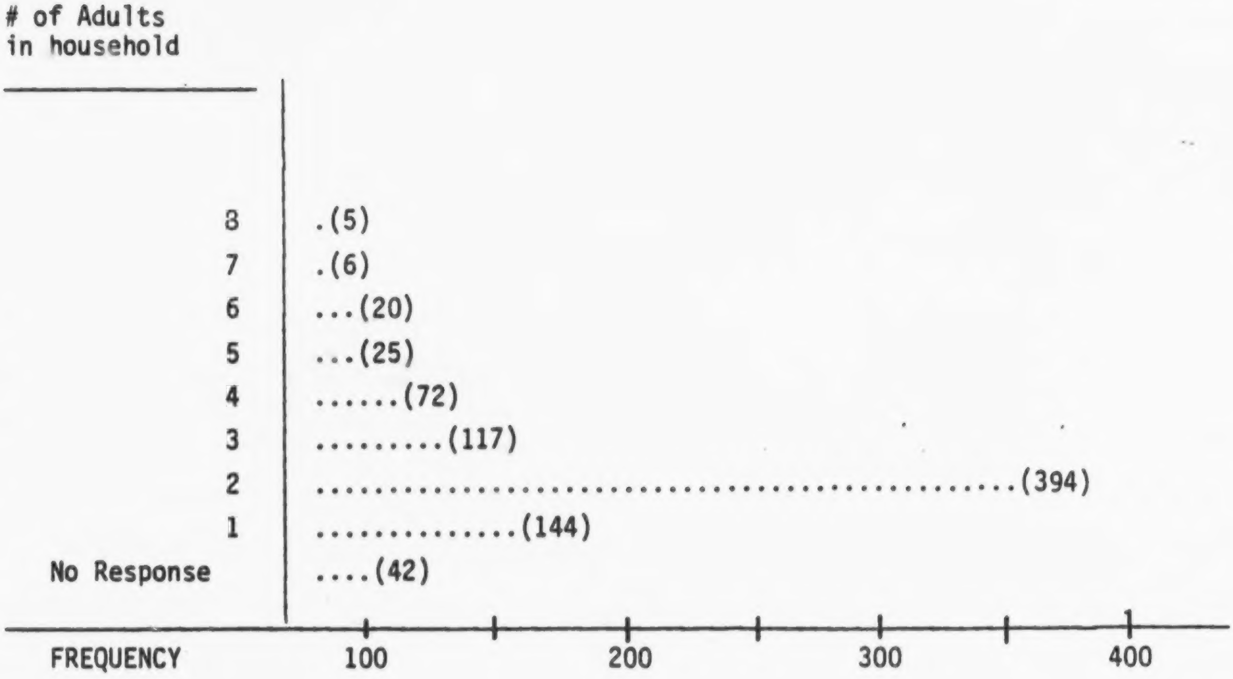
Age of Parents. The relative age of Head Start parents averaged 28 years and represented 8% of the population. In general, ages ranged from 19 years to 63 years of age. It was assumed that parents whose age ranged in the late 50's or early 60's were not always parents of the Head Start children but in fact legal guardians.

Family Size. Parents were asked to report the number of adults (age 19 and over) living in household. The majority of households, 394 (46.6%), represented having two parents. The next highest group were households with one parent, 144 (17%) of the population. The next highest group had three adults in the household and numbered 117 (13.8%) of the population. The remaining households had anywhere from 4 adults (72 or 8.5%) to 9 adults (2 or 0.2%) (table 1). Children in the household were grouped by age (table 2):

Table 1

Number of Adults in Household by Frequency Distribution

(N = 825)



(Missing cases:119)

Table 2

Children in Household by Age Excluding Head Start Child

	N = 655	N = 429	N = 155	N = 77
# of children	under 5 years.	5 to 10 years	11 to 15 years	16 to 18 years
7	-	1	-	-
6	2	1	-	-
5	3	1	1	-
4	17	7	-	-
3	66	22	12	3
2	220	99	28	10
1	347	298	114	64

There were 655 children under 5 years of age excluding the Head Start child. The next group was 5 to 19 years, of which there were 429 children. In the age grouping of 11 to 15 years there were 155 young people. Lastly, in the age grouping of 16 to 18 years, there were 77 children. It can be seen the families in Head Start are relatively young ones which seems to coincide with the average age of the parents.

Family and Friends in Community. These questions were concerned with support systems available to families as a means of coping with problems or concerns in a family. Such systems could mean having someone to care for the child, one who offers advice in certain situations or provides a certain ambiance which enables the family to cope. Of the respondents, 374 (45%) responded they had a few family members. 205 (25%) responded they had many family members, while 248 (30%) answered they did not have any family living in the community (see table 3).

With friends in the community, 493 (59%) responded they had a few friends. 269 (32%) answered they had many friends in the community. 69 (9%) did not have any friends in the community. 14 families did not respond to the question (table 3a).

Occupations. Of the 845 respondents, 282 did not answer this question. However, 231 of the working parents were involved in blue-collar work. That is, any form of employment which required some type of skill. 150 of the parents were involved in labor work which does not always require a set of skills. 21 were involved in white-collar work, while 7 were students. What is significant about this grouping is that 155 of the parents were unemployed.

Table 3

Family in Community as Support Systems

(N = 827)

Response	Number	Percentage
Yes, alot	205	25%
Yes, a few	374	45%
None	248	30%

Table 3A

Friends in Community as Support Systems

(N = 831)

Response	Number	Percentage
Yes, alot	269	32%
Yes, a few	493	59%
None	69	7 ~~8~~%

The factor of unemployment has definite implications towards being in a high risk situation (table 4).

Medical Concerns. The researchers asked parents if they participated in a pre-paid health plan. This is a critical situation for low-income individuals. It is well known that low-income families have a more difficult time in receiving hospital or sometimes medical care because they do not have any form of insurance. Recently, many parents have received Medicare or Medicaid but it is not reflective of the study population. Of concern to the researchers was that not having insurance could very well place a family in a high risk situation. Of 795 respondents, 581 (73%) did not have any form of insurance. 214 (27%) had insurance from their place of employment of through public assistance.

Living Conditions. The majority of the families live in apartments (399). This group is followed by 341 of the families who lived in single-family-dwellings. The remaining families lived in duplexes, mobile homes or had other situations (see table 5). Significantly, the majority of families lived in apartments or single family dwellings, which has obvious implications in those situations where an extended family might find themselves living in overcrowded conditions.

Years at current address. From preliminary findings, the data revealed most of the families were relatively young. This would also seem to be reflected in the years spent at the place of residence. Most families, 38 (47%) of families have lived 1 to 4 years at their current address. 25% of the respondents reported having lived at their current address less than one year. It is possible this group of parents represent, in part, highly mobile or transient individuals which may reflect an element of risk. On the other

Table 4

Occupational Status of Head Start Parents

(N = 564)

Type of Occupation	Frequency	Percentage
Laborer	150	27%
Blue Collar	231	41%
White Collar	21	4%
Students	7	1%
Unemployed	155	27%
Totals	564	100%

Table 5

Living Conditions of Head Start Families by Type of Dwelling

(N = 819)

Type of Dwellings	Frequency	Percentage
Single-Family Unit	341	42%
Duplex	28	3%
Apartment	399	49%
Mobile Home	10	1%
Other	41	5%
Total	819	100%

hand, 28% of the respondents lived from 5 to 15 years at their present address.

Needs Assessment Identification

In this section findings which represent family issues, information on the child and service utilization by families are reported. Data on family issues includes language and intact families. Information on the child addresses health, bed routines and eating habits. Service utilization by families addressed awareness of existing services, use of these services and areas of concern for which parents need services.

Language. The LACA Head Start program has historically served a large percentage of low-income Spanish-speaking people. As indicated by language of preference, this assumption continues to appear true. Of those who responded to this question, 467 (63%) chose to speak only Spanish; 164 (22%) spoke only English; 92 (12%) spoke English and Spanish, and 17 (2%) spoke another language (see table 6).

Table 6

Language Preference of Head Start Parents Based on Frequency Distribution

(N = 740)

Language	Head Start	Parents
Monolingual Spanish	467	63%
English	164	22%
Bilingual English/Spanish	92	12%
Other Languages	17	3%
Total	740	100%

Intact Families. The researchers were interested in knowing how many families were together as a unit and, if possible, the number of single parents. Respondents were asked to respond if mother or father were living at home. Initial responses indicated 755 Head Start mothers and 620 Head Start fathers lived at home and 135 Head Start 135 Head Start single parents. When asked if they were living at home, 620 fathers responded they were while 59 were not. 755 mothers were also living at home while 59 were not (table 7). Of this group, the researchers determined there were 293 single parents based on the number of parents not living at home as well as the difference between Head Start mothers and fathers living at home.

Child Problems. Parents were asked a series of questions regarding their children's overall health. Researchers were concerned with identifying existing problems in order to discover if parents would utilize Head Start's referral system. In general, the questions focused on sleeping and eating habits.

One question which appeared to be constant was a parent's perception of a problem when compared to the assessment by a human services professisonal. There is an apparent chasm in this area, although not serious. Parents, for example, were asked if their children were in good health. Not surprisingly, 798 (96%) of the parents who responded to this question felt their children were, in fact, in good health. Less than 28 (3%) of those who responded felt there was a problem with their child's health, while only 3 individuals chose not to respond (table 8).

The research team then asked if children had received a physical exam in the previous twelve months. The data revealed a larger distribution of responses among the population. 63% (519) of those who responded stated

Table 7

Parents Living at Home

At Home?	Fathers N = 679 \#	 %	Mothers N = 758 \#	 %
Yes	620	91%	755	99%
No	59	9%	3	1%
Total	679	100%	758	100%

Table 8

Child's Health as Perceived by Head Start Parents

(N = 829)

Parents Response	#	%
Good	798	96%
Not Good	28	3%
No Response	3	1%
Totals	829	100%

their children had received a physical exam, (table 9). Still, 69 (8%) of the parents claimed their children were taking some form of medication. This could have been a simple aspirin or prescribed form of medication. 752 (91%) were not taking medication while four parents chose not to respond. Again, it should be noted the researchers were interested in the parent's perception of a child's problem.

Bed Routines. Proper rest is important to a preschool child if they are to do well in school. A situation where for one reason or another, a child does not get proper rest could have negative affects on school achievement. Most families indicated (449 of them) that there was some type of bed routine and usually meant a sibling would assume the responsibility of helping the child on a regular basis at bedtime. Another interesting factor is most children were rising between 7 and 8 in the morning and going to bed between 8 and 9 in the evening.

A series of questions were then asked regarding problems at bed time. 710 (85%) of the parents felt there was some type of problem (table 10). To understand the bed routines the researchers asked if the child shared a bedroom with another member of the family. 140 parents reported the child did share a bedroom while 696 did not. If the child shared a bedroom did the child have his/her own bed? 583 of the parents responded the child did have their own bed. However, only 497 of the children actually slept in their own bed. 18% of the children slept with other siblings, parents, or in some cases, grandparents (table 11). In some cases, the causes of this situation was due to insomnia, nightmares, even sleepwalking. But the overwhelming number of parents felt there were other reasons for this (table 11a).

Table 9

Head Start Children's Reported Status of Health Examinations in Past Year

(N = 823)

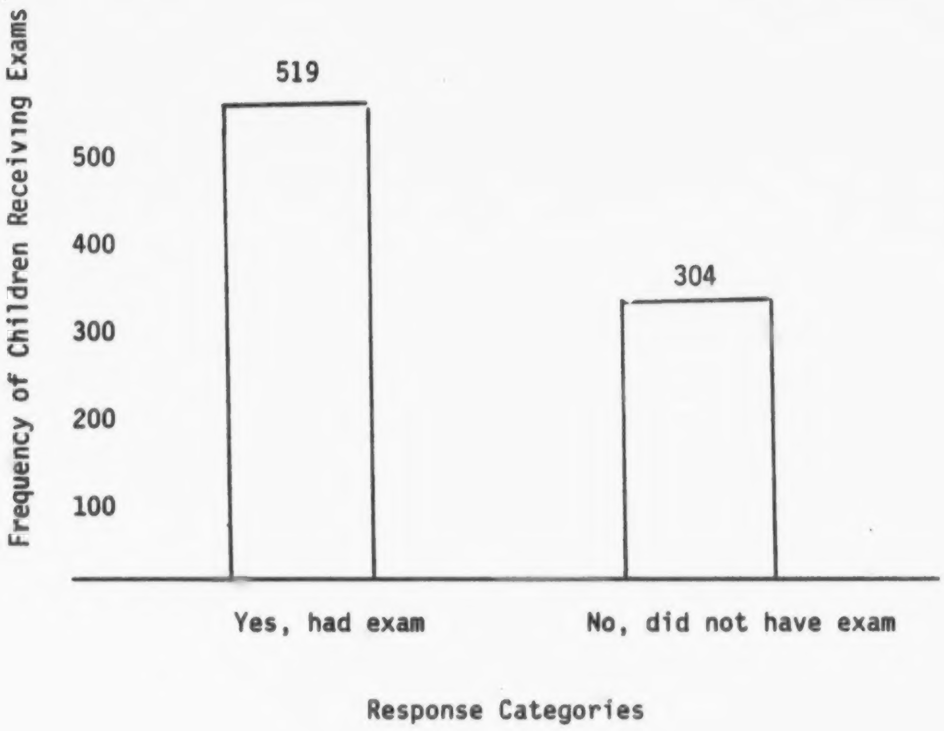


Table 10

Parental Concerns of Child Reported by Head Start Parents

Type of Concern	Frequency of Parent Response[1]	
	Yes	No
1. Problems at bed time (N = 818)	710/85%	108/13%
2. Sleeping Habits		
a. Child shares room (N = 839)	140/17%	696/83%
b. Child has own bed (N = 841)	583/69%	253/30%
c. Does child sleep in own bed (N = 819)	497/61%	149/18%

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[1] The frequency of parent response does not include the number and percentage of no responses.

Table 11

Number of Children Sharing Bed with Others

(N = 315)

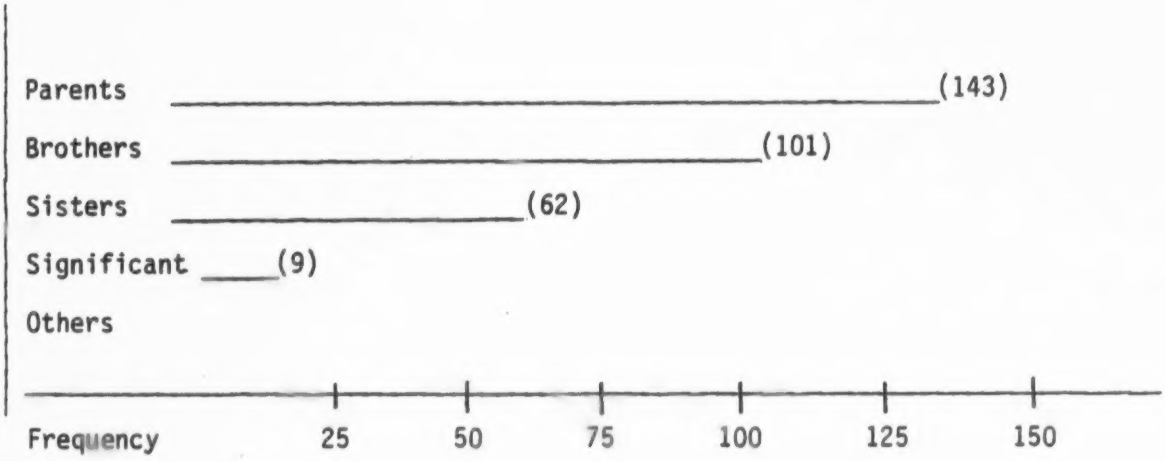


Table 11A

Reasons for not sleeping in own bed

(N = 206)

Insomnia	17
Nightmares	19
Sleep Walking	22
Other Reasons	148

Eating Habits. Most parents, exactly, 69% of them, felt their children had some type of eating problem. These problems were related to the child being a picky eater, a poor eater, or a overeater. On the other hand, 31% of the parents felt that there had never been a problem with their child's eating habits (table 12). At the time the survey was conducted, however, 66% of the parents responding felt their children still had problems with their eating habits (table 12a).

Utilization of Social Services. Another important aspect of the needs assessment and related to social competence was the degree to which parents were aware of, and utilized, social service agencies. The researchers provided a list of 10 existing social service agencies. Parents were asked to note if they were aware of any of the agencies on the list. If they were not, could they give the name of a similar agency. In table 13, parents were generally not aware of the listed agencies. This brings up important implications since it has been documented how low-income Latino families do not utilize human service agencies. When asked if they had used any of these services, 192 (26%) of parents said they had, while 515 (71%) said they had not (table 14). This response changed dramatically when parents were asked if they would ever use these services. 470 (69%) said they would while 146 (21%) said they would not.

Parents were then asked about specific services they might feel a need for. They could respond in 4 ways: just need the information, have utilized in the past year, need for the service now and no need for service. The first response, it was surmised, placed the individual at medium risk since they sought help but this was no indication of the problem being resolved. On the other hand, if someone needed the service right away, they were considered to be at high risk.

Table 12

Eating Difficulties with Child Reported by Head Start Parents

(N = 818)

Do problems exist	# of parents responding	
Yes, there are difficulties	566	69%
No, there are none	252	31%

Table 12A

Parental Concerns with Child's Eating Habits

(N = 816)

Do problems exist	# of parents responding	
Yes, there are concerns	542	66%
No, there are none	274	34%

Table 13

Knowledge of Social Service Agencies

Agency Listing	Yes, knew	Did not know	No Response
Manos de Esperanza (N = 666)	21/3%	633/95%	12/2%
Centro de Amistad (N = 668)	51/8%	607/91%	10/1%
S.F.V. Child Guidance Clinic (N = 662)	79/12%	573/87%	10/2%
Friends of the Family (N = 657)	42/6%	605/92%	10/2%
Family Connection (N = 655)	22/3%	623/95%	10/2%
Coldwater Canyon Hospital (N = 651)	37/6%	602/92%	12/2%
Department of Social Services (N = 667)	236/35%	426/64%	5/1%
Alcoholics Anonymous (N = 660)	127/19%	525/80%	8/1%
NAR-Anon (N = 656)	45/7%	598/91%	13/2%
Family Service of L.A.	41/6%	591/91%	15/2%

Table 14

Utilization Patterns of Services and Help Seeking Behavior

Questions	Frequency of Response			
	Yes	%	No	%
Have you used (N = 726) any of the agencies described?	192	26%	515	71%
Would you use (N = 680) any of these agencies described?	470	69%	146	21%

In table 15, parents were asked to indicate their level of need based on type of service. For those individuals who needed information regarding services, responses indicate English as a Second Language (ESL) ranked highest with 138 responses. This was followed by information on medical needs with 110 responses and information on adult education with 104 responses. It can be deduced that with one segment of the study population there is an interest in finding resources for language learning as well as resources for adult learning.

Those individuals who had utilized services in the past year were few and 20 of them receiving services related to D.P.S.S. issues. 15 individuals received individual counseling, 14 received services regarding medical needs, 11 received psychological services, emergency food, and family counseling respectfully. Only 10 received employment related services. The small number of parents who received services in the past year seems to substantiate the small number of individuals who utilize social services.

Responses indicating a need for immediate services reflected possible circumstances related to risk. ESL was ranked highest with 72 responses which indicates that at least some parents want to strengthen their English skills. Need for clothing was next highest with 68 responses followed by a need for medical services with 58 responses, employment needs with 55 responses and housing needs with 53 responses.

With these basic concerns, the research team was also interested in how parents perceived the role of Head Start in helping their children. It is part of Head Start policy to provide an orientation to the parents about the Head Start program; what the program does and does not do. This survey took place well after the orientation, so it afforded the research team an

Table 15

Reported Needs of Head Start Families

	Need Service Information #	Services Utilized In Past Year #	Need for Service Now #	No Need for Service #
Financial Needs (N=553)	46	7	29	471
Spouse Abuse (N=554)	23	6	6	519
Child Abuse (N=554)	26	3	8	517
Alcohol/Drug Abuse (N=554)	27	6	9	512
Psychological Services (N=550)	43	11	21	475
Crisis Intervention (N=551)	56	8	29	468
Medical Needs (N=557)	110	14	58	375
Shelter (N=557)	51	12	37	457
Food (N=555)	84	11	57	403
Clothing (N=554)	76	3	68	407
Family Needs (N=549)	67	11	37	434
Individual Counseling (N=550)	34	15	25	476
D.P.S.S. Problems (N=553)	26	20	23	484
Employment (N=555)	69	10	55	421
Housing Needs (N=550)	90	2	53	405
Legal Assistance (N=548)	53	3	27	465
Immigration (N=549)	76	5	48	420
ESL (N=553)	138	3	72	340
Adult Education (N=553)	104	3	41	405
Vocational Training (N=553)	45	2	26	480
Translation Services (N=553)	25	3	16	509

opportunity to see if the orientation created any major expectations. 84% of the parents surveyed had concerns about their children for Head Start teachers. Moreover, this led to some expectations from parents regarding the benefits they wanted their children to receive as a result of participating in the program. 98% of the parents surveyed had an idea of the benefits they wanted for their child. For example, parents wanted their child to successfully learn to interact with other children, develop their cognitive skills, improve their language skills, learn to share, and most importantly, be prepared to enter public school.

Indicators of High Risk

In arriving at a sense of what it meant to be in a high risk situation, the research team considered those issues or problems which were significant to the parents. The basic questions to be answered were: what conditions, missing from the daily life of a family, will cause a high risk situation? We were guided by the fact that any number of problems could cause high risk. We thus agreed multiple problems were to be considered in determining high risk among this population.

We began by grouping a set of variables related to high risk. The first grouping brought together three variables related to family life. Two of those variables were related to family support systems in the community (friends or family). It was assumed that these support systems are important in helping families cope in times of stress. In relation to family support systems, 25% responded that they did have a family member; 45% responded that they had only a few family members in the community while 30% did not have any family at all in the surrounding community (table 16). In the category of friends as support systems, 32% responded they had friends in the

Table 16

Family and Friends in Community

	#/%	#/%
Yes, alot	205/25%	269/32%
Yes, a few	374/45%	493/59%
None	249/30%	69/8%
	Family in Community (N = 828)	Friends in Community (N = 831)

community, 59% said they had a few friends, and 8% did not have any friends in the community. Those who had only a few family and friends or none at all were considered possibilities for being at risk. A third variable in this grouping had to do with having pre-paid insurance. Not having such insurance made a family a likely candidate for high risk (table 17). 72% of the Head Start parents (N=785) did not have any form of insurance. This supports the finding of a study conducted by Walden, Wilensky, and Kasper (1985) which found that 13.6% of the Hispanic population were uninsured. They write:

> The population groups most likely to be uninsured all year were, by definition, those least likely to have private coverage but ineligible for public programs. The groups most likely to be uninsured part of the year were similarly distributed, although some exceptions were noted. Thus, the likelihood of having no coverage for health care expenses throughout the year or part of the year was well above the national average for young adults aged 19 to 24, Hispanics and Blacks, and the poor and other low income groups (p.3).

Table 17

Pre-paid Insurance for Head Start Parents

(N = 809)

Parents Response	#	%
Has Insurance	214	26%
No Insurance	581	72%
Totals	795	98%

No response to question = 14

A second area where variables were grouped as determiners of high risk related to the child's eating and sleeping habits. As previously mentioned, a large number of parents had definite concerns with their children's eating habits and those children who shared a bed with a family member were considered candidates for high risk (tables 10-12). Situations which lead to a medium or high risk situation were those where children who had their own bed slept with significant others for reasons of insomnia, nightmares or related problems. On the other hand, parents were also concerned with their children's eating habits. Some children were reported as being picky eaters, poor eaters or overeaters.

A third category of variables concerned child care; one of which examined the affect of a child living for any duration with another family member or legal guardian, the other examined the effect of living of being under the care of a babysitter. The research team assumed that in some cases behavioral problems could arise in some children by being separated from their parents for various periods of time. Taken by itself the data here was not very significant. In few cases did a child live with other family members or guardian(s). In fact, 751 or 90% of the parents denied their children lived for long periods outside the home although some noted that some time was spent with grandparents or significant others. Usually the time away from the home was no more than two weeks, and usually did not produce any significant changes in the child's behavior. On the other hand, 70% of the parents indicated their children did receive some type of child care. Most of the children were cared for because both parents were working and the duration ranged from one to 4 years. For the most part, the children reacted very well to these experiences.

Follow-up Assessment Comparisons

The follow-up assessment was conducted in May of 1985, one month before school was to end. Originally, the assessment was to be implemented with the same population that participated in the needs assessment but because of time and budgetary matters, the research team decided to implement the assessment with a sample population. Selected to be in the study were those Head Start sites with the largest number of referrals to the mental health component. These were four sites with multiple classrooms. As in the needs assessment, teachers implemented the follow-up assessment with parents and returned to the research team 220 completed interviews. The data was coded, keypunched and entered into a computer.

The finding showed some changes had occurred with the population over the school year. For example, in the needs assessment, the researchers asked if parents participated in a pre-paid health plan. 581 responded they did not while 214 said they did. It was assumed that not having prepaid insurance was definitely courting a possible high risk situation. This problem did not change over the year. Even the smaller sample of the follow-up assessment indicated a high percentage without pre-paid insurance: 197 without insurance as compared with 20 with insurance (table 18).

Table 18

Prepaid Health Insurance:
Need Assessment and Follow-up Assessment Comparisons

	N = 804	N = 221
Response	Pre-Need Assessment	Post-Need Assessment
Yes	214	20
No	581	197
No response	9	4

The health of the child seemed to remain stable according to parents perceptions. As reported in the needs assessment, 96% of the parents saw their children in good health. In the follow-up assessment 94% of the parents reported their children as being in good health with 6% of the children not being in good health (table 19). Parents were also asked if their children had received a physical exam during the school year. In the needs assessment, 63% of the parents overwhelmingly reported their children had received a physical exam while in the follow-up assessment 87% of the parents reported the same. This obviously had much to do with Head Start's concern and orientation toward the child's physical health (table 20). Parents were then asked to respond if their children had been ill in the last year. 21% of the parents reported their children had been ill while 76% of the parents reported their children had not been ill (table 21).

As in the needs assessment, data indicated children did not generally live outside the home with other family or significant others for long durations of time, if at all. In the needs assessment, 90% of the parents responded their children did not live for a long duration with others. 93% of the parents responded similarly in the follow-up assessment. There were some differences, however, regarding actual child care services. 70% of the parents in the needs assessment reported their children received some form of child care. However, in the follow-up assessment, 70% of the parents indicated their children did not receive child care; presumably because of their children's participation in Head Start.

In summary, the needs assessment was designed to elicit information on children and families in Head Start. Data on family, child, knowledge of social services, factors relating to high risk and a follow-up assessment

Table 19

Parents Reporting on Child's Health: Need Assessment and Follow-up Assessment Comparisons

Response: Is your child in good health?	Needs Assessment #	Needs Assessment %	Follow-up Assessment #	Follow-up Assessment %
Yes	798	96	207	94
No	28	3	13	6
No response	3	1		
Totals	N = 829	100%	N = 220	100%

Table 20

Frequency of Children Having a Physical Exam as Reported by Parents

Response: Has your child had a Physical Exam?	Needs Assessment #	Needs Assessment %	Follow-up Assessment #	Follow-up Assessment %
Yes	519	63	193	87
No	304	37	27	13
No response	5	-	-	-
Totals	N = 828	100%	N = 220	100

Table 21

Parents Reporting on Children Being Ill in Past Year in Follow-up Assessment

Response by Parents	#	%
Yes	46	21
No	166	76
No response	5	3
Totals	217	100

comparisons were provided. The instrument was valuable for providing insight on conditions, issues or attitudes parents may have regarding their children or themselves. Although its use has provided valuable information on Head Start parents, further studies utilizing the assessment would lead to refinement and thus more concrete data.

This is not to belittle the data derived from MHP/IP study, but rather to point out the strength of any research instrument must be built on continued testing and refinement. In the scope of things, the needs assessment was used to also show the strengths of families. The researchers were not interested in "discovering" so-called pathologies in order to rationalize treatment. As such, the Family Social Competence Survey was designed to complement the needs assessment and will be the subject of the following chapter.

Chapter 7

THE FAMILY SOCIAL COMPETENCE SURVEY

Overview

As previously discussed in chapter 3, the original intent of Head Start was to promote social competence in children. Yet, for a variety of reasons, social competence has not received the attention it deserves. Although researchers have continued to suggest the importance of social competence in relation to the child, attempts at developing outcome measures have fallen short.

The MHP/IP study had as one of its goals the identification of factors associated with the social competence of the family. Identification of these factors, it was felt, would serve to enhance the ability for early identification and early intervention with Head Start children and families. It would also serve to indicate the relative strength of the family in coping with daily life. This is probably the most important reason for conducting the survey of social competence: to point out the strengths of families underscores the need for human service professionals to work with families as partners not as individuals. Thus, the four factors identified by the research team for the survey were: 1) language use and bilingualism, 2) family needs, 3) interest in community affairs, and 4) parent attitudes towards education.

Language Use and Bilingualism

One factor in coping with the surrounding environment has to do with language use. This is especially important for families who utilize language other than English. Not having a rudimentary understanding can, and has, subjected the individual to situations where employment, for example, may may be denied due to a lack of English speaking skills. This is also evident in the school system where countless youngsters are enrolled in English-as-a-Second language (ESL) classes. In short, a lack of English speaking skills can close the door to mobility for many.

Factors for not learning another language include, lack of time due to work and family responsibility, no encouragement to learn another language in their country of origin, lack of literacy in their native tongue, little academic training, and difficulties inherent in the English language. Nevertheless, individuals living in this country have for some time encouraged their offspring to learn another language because it is considered a springboard to educational and employment opportunities.

Parents were asked if they preferred to speak and write in English. 565 (73%) of the parents strongly agreed or agreed with this approach. 89 (12%) were undecided and 109 (15%) disagreed or strongly disagreed. While this appears to be a contradiction of sorts when considering the majority of the population are Latinos, it was not surprising to know most of these families use Spanish at home (table 6) thus giving credence to the notion English should be used in public. This is supported by two additional statements concerned with bilingualism.

One, parents were asked to respond to the use of two languages as a means of participating fully in society. 706 (88%) of the parents strongly agreed or agreed with this statement, 30 (4%) were undecided and 57 (7%) disagreed with use of bilingualism. Second, a related statement asked if the non-English speaker should learn another language without forgetting their native language. 752 (95%) of the parents felt this to be important. 23 (3%) were undecided and 17 (2%) disagreed (table 22). What this data tells us is that parents, in total, believe it is important to understand and be able to use English. On the other hand, they also believe that bilingualism is a positive skill for being able to cope in society, especially one so culturally diverse as the United States.

Family Needs

Concern for the basic needs of the family is a requisite generally agreed upon by all who live within the structure of such a unit. It is a crosscultural factor that cuts over class, economic, and political boundaries. But the literature on the poor has generally classified them as having disadvantaged families, broken and unorganized as a unit. In these situations, basic needs go unmet. While the researchers do not deny the existence of these situations, the authors do not agree that their conditions are the result of being disadvantaged. In fact, all families begin with a sense of, or meeting the obligations of, family needs. However, other circumstances tend to make this impossible. In a family where there is unemployment, there is also little income and in a family where there is little income, there is little opportunity for meeting needs.

The research team was concerned with discovering a parent's attitudes toward family needs. It was assumed that regardless of the situation, attempts would be made to provide for the family's well being. Not being able to provide for these needs does not mean the existence of a deficiency, but rather, the existence of external factors which prevent individuals from successfully providing for the family.

Parents were asked to respond to a statement claiming the wellbeing of the family was a responsibility all parents must accept. 770 (98%) strongly agreed or agreed with this. 10 (1%) were unsure and 6 did not agree (table 23). The researchers then wanted to know what parents would do in times of financial

Table 22

Attitudes of Head Start Families Towards Language Use and Bilingualism

	Preference in the use of English (N = 767)	Learning two languages (N = 797)	Non-English Speakers Should learn English without forgetting native language (N = 793)
Strongly Agree	295/38%	408/51%	473/60%
Agree	270/35%	298/37%	279/35%
Undecided	89/12%	30/4%	23/3%
Disagree	82/11%	42/5%	11/1%
Strongly Disagree	27/4%	15/2%	6/1%
No Response	4/1%	4/1%	1

Table 23

Perception of Family Wellbeing by Head Start Families

Responses	Family Wellbeing (N = 796)	Putting food on the table (N = 801)	Shelter/not worrying about other problems (N = 773)	Money for family purpose rather than personal use (N = 778)
Strongly Agree	533/67%	655/82%	96/12%	499/64%
Agree	247/31%	144/18%	152/20%	233/30%
Undecided	10/1%	1	82/11%	14/2%
Disagree	3	1	295/38%	25/3%
Strongly Disagree	3	-	148/19%	7/1%

shortage. Would food be on the table? 799 (98%) agreed they would insure this. 1 person was undecided and 1 individiaul disagreed. Two additional statements were asked. The first claimed that as long as the family had shelter, it was not necessary to worry about other problems. Again, the concern of the researchers was to show that individuals would look after the family. But parents apparently took this statement to mean that as long as one has shelter, who cares about other problems! This is the only explanation when examining the data. 248 (32%) parents agreed with the statement. 82 (11%) were undecided and 433 (57%) disagreed with the statement altogether. This tells us that parents at least feel problems should be dealt with. These statements reflect a level of competence which has not always been acknowledged in the literature. The second statement asked if it was more important to use money for family purposes rather than for personal enjoyment. As with the preceding statements, parents continued to show a concern for family wellbeing. 732 (94%) of the parents agreed with this idea. 14 (2%) were undecided and 32 (4%) disagreed with this.

But with all this concern it was realized family leisure was also important to social competence. If a parent works nights, comes home when the children are asleep, does not see the children when they go off to school, there is a certain kind of resentment which builds up in the children and could create problems in the relationship with the child and the parent. The researchers wanted to understand parent attitudes toward leisure with the family. 765 (98%) of the parents agreed leisure time with the family is very important. 8 (1%) were undecided and 3 disagreed that leisure was important (table 24).

Table 24

Importance of Family Leisure Time to Headstart Families

(N = 777)

Response	Frequency	%
Strongly Agree	538	69%
Agree	227	29%
Undecided	8	1%
Disagree	3	1%
Strongly Disagree	-	-
No Response	1	

Table 25

Parents Concern for Others in the Local Community

(N = 728)

Response	Frequency	%
Strongly Agree	189	26%
Agree	365	50%
Undecided	121	17%
Disagree	33	4%
Strongly Disagree	16	2%
No Response	4	1%

Interest in Community Affairs

One of the hallmarks of a successful community is a concern for its members. Participation with local institutions such as schools and churches indicates a regard for the meaningful relationship between individual and institution. Among low income parents, there should be evident a knowledge of local community institutions and with it, an attitude regarding the role of each.

Parents were asked if by supporting other individuals would they show a concern for the community? The researchers were attempting to get a sense of the attitude towards helping others and thus their support for the overall foundation of the community. 554 (76%) of the parents felt agreement with this notion. However, 121 (17%) were undecided, which may indicate that perhaps it is better to keep to oneself or perhaps they had some experience which had given them a sense of doubt regarding such support. Finally, 49 (6%) disagreed with this statement altogether (table 25).

A similar statement was given to the parents but was more concerned with local institutions such as schools, churches and civic groups. 652 (86%) of the parents tended to believe that such support was important (table 25a). 90 (12%) were undecided and 12 (2%) disagreed. There is a slight difference but more families will support institutions although the specific reasons for this are unclear.

Parent Attitudes Towards Education

It has long been assumed low income individuals are not concerned with the education of their young. Because of their social status, the lack of interest displayed by parents naturally affects the perception and motivation of the offspring regarding the importance of education. The researchers had a

Table 25A

Concern for Community

(N = 758)

Response	Frequency	%
Strongly Agree	248	33%
Agree	404	53%
Undecided	90	12%
Disagree	6	1%
Strongly Disagree	6	1%
No Response	2	-

Table 26

Parents Response to Financially Wanting to insure Future Plans for Child's Education

(N = 781)

Response Category	Frequency	%
Strongly Agree	502	64%
Agree	265	34%
Undecided	10	1%
Disagree	3	1%
Strongly Disagree	1	0

concern about these views, especially in light of the culture of poverty model. In a series of statements parents were asked to respond about planning for the future and expectations for and participation in their child's education.

The first statement, if parents had a greater income they would put some of it aside for their offspring's education, 767 (98%) of the parents agreed they would do this. 10 parents were undecided and 4 parents disagreed (table 26). This seems to say parents do think about future plans. But if they do not plan is it because they do not care for their children or is it because there are extenuating factors that prevent them from doing so?

Parents then responded to a statement indicating their child should graduate from high school and get a job. 366 (48%) of the parents indicated agreement. 76 (10%) were undecided and 321 (42%) disagreed. The responses here were almost even but when parents responded to a statement indicating their children should graduate from college, the scales were tipped. 708 (91%) agreed their children should go this far. 57 (7%) were undecided and 14 (2%) disagreed. This indicates low-income parents do have an interest in what their children do and would like to see them go well beyond high school (table 27 and 28).

To that end, would parents participate in their children's education if it meant helping to improve educational achievement. 782 (99%) of the parents responded they would while only 11 said they were undecided and 2 parents disagreed (table 29). It is not hard to figure that parents are willing participants if agencies provide the vehicle for participation and parents are allowed to empower themselves by participating in things related to what they want to do, not what a professional thinks they need to do.

Table 27

Head Start Parents Attitudes About Whether Their Child Should Graduate From High School

(N = 763)

Response Category	Frequency	%
Strongly Agree	201	26%
Agree	165	22%
Undecided	76	10%
Disagree	183	24%
Strongly Disagree	138	18%
Column Total	763	100%

Table 28

Head Start Parents Attitudes About Whether Their Child Should Graduate From College

(N = 779)

Response Category	Frequency	%
Strongly Agree	470	60%
Agree	238	31%
Undecided	57	7%
Disagree	12	2%
Strongly Disagree	2	-
Column Total	779	100%

Table 29

Head Start Families Reported Willingness to Participate in Child's Education

(N = 795)

Response Category	Frequency	%
Strongly Agree	489	62%
Agree	293	37%
Undecided	11	1%
Disagree	1	-
Strongly Disagree	1	-
Column Total	795	100%

Overall, parents perceive themselves as very competent. They seem to know what they want. But from practice this also seems a contradiction. Since the level of participation from parents has been criticized from various quarters it seems parents are still viewed from the lens of any number of deficit models. The lack of participation of parents does not seem to be their fault but rather of an entrenched system which prevents authentic participation. Head Start parents indicate a willingness to participate and assume a responsibility in their children's education according to these findings. Head Start families do see the value of the family and community in their attempts at survival and self determination. Head Start families do feel competent in addressing their need for the well-being of the family. What has been represented in both chapters 6 and 7 is a need for increased resources, education, information and systems to this high risk family group to better bridge the gap between how one perceives their level of social competence and the reality of one's social competency.

SECTION II

THE FINDINGS

Chapter 8

STAFF TRAINING AND CONSULTATION FINDINGS

Overview

As previously stated, one of the three preventive mental health strategies of the MHP/IP was staff training and consultation. The literature has indicated that consultation is an important aspect of community mental health programs. In Head Start, consultation is an effective means of providing training to teachers in promoting the emotional and social development of children. This chapter presents the findings for staff training and consultation of the 128 teaching staff and includes the following: 1) the Mental Health Classroom Observation/Supervision Cycle evaluation of teacher performance and classroom environment, 2) Teacher Feedback for the Mental Health Classroom Observation/Supervision Cycle, 3) the Mental Health Individual Child Observation/Action Plan, and 4) the Mental Health Component Evaluations.

Mental Health Classroom Observation/Supervision Cycle

The Mental Health Classroom Observation/Supervision Cycles took place in each of the 64 classrooms in the first few months of the program. The mental health staff evaluated 1) teacher performance and 2) classroom environment and rated them on a scale of 1 to 5, 1 being unsatisfactory and 5 excellent. The following table shows the results of this evaluation (Table 30).

In the category of Teacher's Performance, LACA's teachers exhibited the highest level of skills (ranking over 50% in the Good/Excellent category) in the areas of 1) interactions with children - 52.53% and 2) consistency and fairness - 54.22%. The areas where teachers exhibited the lowest level of

Table 30

Mental Health Observations of Teacher Performance and Classroom Environment

(N = 64 Classrooms)

TEACHER'S PERFORMANCE	Unsatisfactory or Needs Improvement	Satisfactory	Good/ Excellent
Behavior Management	20.3%	30.5%	49.14%
Child Support/ Reinforcement	18.63%	35.59%	45.75%
Interactions with children	8.47%	38.98%	52.53%
Communication Skills	16.94%	37.28%	45.75%
Nurturing child's self-esteem	20.32%	32.2%	47.44%
Consistency/fairness	13.54%	32.2%	54.22%
Children's needs appropriately met by teachers	18.63%	38.98%	42.36%
CLASSROOM ENVIRONMENT			
Emotionally healthy/ supportive	13.54%	30.5%	55.92%
Level of positive stimulation	22.02%	32.2%	45.75%
Positive Social Interactions; child/child	15.24%	33.89%	50.83%
Positive Social Interactions; child/adult	15.24%	37.28%	47.45%
Positive Social Interactions; adult/adult	40.66%	18.64%	40.67%

skills (over 20% in the unsatisfactory or needs improvement category) were 1) behavior management - 20.3% and 2) nurturing the child's self-esteem.

Similarly, in the category of Classroom Environment, teacher's exhibited the highest level of skills (again, ranking over 50%) in the categories of 1) emotionally healthy/supportive - 55.92% and 2) promoting positive child/child social interaction - 50.83%. Conversely, the lowest level of skills were in the areas of (ranking over 20%) 1) level of positive stimulation and 2) promoting positive adult/adult social interaction.

Teacher Feedback of the Mental Health Classroom Observation/Supervision Cycle

Following the Mental Health Classroom Observation/Supervision Cycle, the teachers completed the Teacher Feedback form on which they gave their comments on the cycle. Table 31 shows the results.

Table 31

Teacher Feedback of the Mental Health Classroom Observation/Supervision Cycle

- LACA's total number of teachers (including assistants)	128	
- Total number of responses (58% of teachers responded)	75	
Number stating cycle was helpful	67	89%
not helpful	8	11%

89% of the teaching staff stated that the Mental Health Observation/Supervision Cycle was helpful. The following are some of the comments the teachers made concerning the cycle:

- it was helpful that the counselors were bilingual
- counselors showed concern for all the children, especially those with special needs
- counselors provided insights in the emotional development of the children
- constructive suggestions were made to improve the general classroom environment and increase children's participation
- teachers felt that there had been a sharing of ideas between themselves and the counseling staff
- teachers gained confidence in their skills
- suggestions were given for promoting children's communication skills
- teachers appreciated having an outside objective viewpoint
- counselors often noticed problems that the teaching staff had overlooked

In comparison, 11% of the teachers found the cycle not to be helpful. They expressed the following criticisms:

- teachers thought that some parents were intimidated by the presence of classroom observers
- observations were disruptive
- on occasion not enough notice was given for site visits
- cycles should have been later in the year so that teachers and children could have adjusted to the new classroom environment

Mental Health Individual Child Observation/Action Plan

When a referral was received, a mental health counselor conducted a classroom observation of the child. A Mental Health Individual Child/Action Plan was completed and provided the foundation for staff training to provide an emotionally supportive classroom environment. There was a minimum of 2 hours of observation per referral, followed by 1 hour of consultation with the teachers. For program year 1984-85, the mental health component received 199 referrals and 168 of these reached the classroom observation stage. With a minimum of 3 hours of observation and consultation per referral, a total of 504 hours were provided.

Five examples of Mental Health Individual Child Observation/Action Plans are presented. Each example includes the presenting problem of the case, a classroom observation, and an action plan. To ensure confidentiality, the names of clients have been changed. It should be kept in mind that the classroom observation and action plan represented only the first stage of assessment and treatment services. As specified in the procedures section of Chapter 5, each case involved the following steps: (1) teacher contact, (2) classroom observation/action plan, (3) parent/teacher conference, (4) preliminary, (5) screening, (6) staffing, (7) interpretive, (8) continued treatment services, and (9) eight week review.

Case #1

> Hilda R., 4.3 years old, was referred because she refused to speak during the first 3 weeks of school, she did not follow directions, and threw tantrums. The following classroom observation was made: she cried when she did not get her way or when she was frustrated, ran around the classroom, threw toys and pushed children in order to get close to the teacher who was reading a book. She didn't cooperate with the teacher. At circle time, Hilda was the loudest most disruptive child, and on the playground she tended to play by herself. At one point, she hit the playhouse with a board or used inappropriate language at times with teachers and peers. Throughout the afternoon the teachers had to constantly talk to her about her behavior.
>
> An Action Plan was designed encouraging teachers to assist the child to verbalize feelings and to find appropriate expressions for her anger and frustration. Teachers are to encourage interaction with peers and to encourage her to pick a partner to play with at work time. Teachers are to model using low voices in order to discourage yelling. Teachers will help to develop Hilda's sense of responsibility by encouraging her to help set the table, serve food, clean up. Teachers are to follow-through on consistant limit setting.

Case #2

Tomas M. was 4.5 years old at the time of referral. He was referred by the teacher for speech problems due to the fact his mother, who had psychological problems, had just died. During the observation the counselor noted that during small group time he played with playdough, demonstrating good concentration. However, he did not interact with peers. When the teacher approached him and talked to him about his work he drew away and was non-responsive. During outside time he was involved in parallel play, with a definite lack of peer interaction. His sand play consisted of pounding a stick into a container of sand. Much of his play was below age-appropriate level. He did not speak and only communicated by making noises. He moved frequently from one activity to another and he especially enjoyed the punching bag. The child is very withdrawn and his development appears below age-level.

An Action Plan was drawn up recommending that the teachers continue speaking and playing with him even when he is non-responsive. They are not to pressure him to respond to questions. They are to assist Tomas in gaining a sense of trust, stability, and security in the classroom. Steps should be taken to help him take an active role in the class, even if he chooses not to be verbal, for example, let him set the table, serve food, pick out a book to be read to the group. Child is to be referred to Handicap Services for additional evaluations.

Case #3

Jaime S., age 4.8 years, was referred for speech problems. Two classroom observations were done. During the first one he isolated himself from the group and ran around the classroom, hoping the teachers would chase him. During the present observation there was an improvement in Jaime's behavior. He was able to follow-through on directions and had increased his vocabulary. At group time he sat with the other children, although he did not interact with them.

An Action Plan was designed to encourage Jaime to participate in group activities by giving him responsibilities within the group such as choosing a song to sing, picking a book to read, etc. By increasing his group interaction, Jaime's sense of confidence may increase. Teachers are to take time daily to give him individual attention, speak with him, encourage him to express his feelings, and praise his positive behavior.

Case #4

Robert T., age 3.5 years, was referred because he would bang his head at night and had been previously physically neglected/emotionally abused. He was presently living in a foster home. It was observed that the child was withdrawn. At times, he had limited and unclear speech, showed difficulty in understanding directions and made no attempt to interact with peers and teachers. He lacked follow-through on activities and became angry when peers failed to understand him. There were difficulties in gross and fine motor activities. At other times the child had severe acting out tantrums that completely disrupted the entire classroom.

The Action Plan recommended teachers continue to provide a loving, supportive and trusting environment. Teachers will begin to withdraw their constant attention from Robert and nurture his interactions with other children. Teachers will not single Robert out but engage him as you would any other child in helping activities and all other activities to foster his independence and self-esteem. Teachers will assure Robert of their continuous presence and of continuity of the environment (i.e., food, nurture object constancy). Teacher will use appropriate materials/books with Robert and the class, not books with disruptive or scary situations. Teachers need to give clear messages to Robert and maintain consistent follow-through.

Case #5

Sandra C., age 4.2 years, was referred for short attention span, aggressive behavior, and poor peer relations. During the classroom observation Sandra was fighting with the child next to her. She kicked him and cursed at him. The teacher told the child that she would have to go to the bathroom if she wanted to curse. The teacher said, "you can curse all you want in there." Sandra frequently sucked her thumb. When asked what she wanted to do, she responded easily. The child appeared to need a lot of adult approval and needed to be physically close to adults. She exhibited a very short attention span. She often took things from other children. She frequently placed toys in her mouth and was unable to maintain eye contact.

The Action Plan recommended that the teacher make meaningful contact with Sandra during planning time, focus on eye contact and physical contact. During work time teachers will see that the child is following through with her initial plan and assist her if necessary. Teachers will work with her on using her words, rather than using force, and on finding appropriate ways to express her emotions. Teachers will be consistent in setting limits. They will be consistent and move in on acting-out behavior. They will keep observation notes on this child. Counselor will meet again with teachers in approximately 1 month to discuss further recommendations.

The eight week final review demonstrated the effectiveness of mental health service delivery and in particular, the effectiveness of the staff training and consultation (see Chapter 10). Of the cases that received Individual Mental Health Child Observation/Action Plans, in 89% of the cases the problem had been resolved and in 11% of the cases the problem had not been resolved.

In addition to the three preceding staff training strategies already discussed, the mental health staff provided a minimum of 1½ hours per referral (199 referrals) of additional training and consultation to the teaching staff. This additional training and consultation added to a total of 300 hours. Examples of these included: periodic telephone calls to discuss the effectiveness of the action plan recommendations, and, if necessary, to plan new strategies to assist the teacher in the classroom. The importance of consistency in emotional and behavioral strategies was explained to the teacher. As a result, a coordinated plan of home intervention by parents and classroom intervention by the teachers was designed. If the teacher reported that the problem had been alleviated and if additional training were required, a second classroom observation was scheduled followed by another training session with the teachers.

The following were the hours spent for staff training and consultation:

Mental Health Classroom Observation/Supervision	352 hours
Mental Health Individual Observation/Action Plan	504 hours
Additional Staff Training	300 hours
Total hours for staff training and consultation	1,156 hours

Staff Evaluation of Mental Health Services

In February 1985, all of the components were evaluated by the teaching staff. The areas evaluated were: 1) helpful services; 2) services most valued; 3) inappropriate services; and 4) lacking or insufficient services.

The following are the teachers' responses:

1) Helpful Services

- provided classroom management strategies
- counselors were dependable and informative
- they showed concern for children and families
- classroom observations were helpful
- training from Observation/Supervision Cycles was helpful
- counseling with parents and children was effective
- counselors responded quickly to referrals
- component provided support and concern for families
- family therapy was provided that involved the entire family
- marriage counseling was given when appropriate
- parent education was made available
- parents were involved in the problem-solving process

2) Services Most Valued

- the counselors gave adequate time for talking with teachers about classroom problems
- they showed concern and care for children and families
- help was given to special needs children
- all the counseling services were helpful
- training was useful for dealing with emotional and behavioral problems
- component was always available for staff consultations

3) Inappropriate Services

When the teachers were questioned about the inappropriate services to teachers, children, and parents, the majority (54%) said they had no complaints. The following were the only other comments given for inappropriate services:

- faster response needed for referrals
- more follow-through needed
- children were taken care of by another adult during parent/teacher conference
- inconvenient location for counseling
- meetings after work hours
- when parents refuse treatment services, teachers still want mental health services in the classroom

4) Lacking or Insufficient Services

The teachers mentioned that certain services were lacking or insufficient. 13% wanted a faster response to referrals and 9% wanted more teacher education. The following comments were also made:

- more notice given for site visits
- provide home visits
- increased communication between mental health component and teachers

In summary, it is clear LACA's teaching staff perceived staff training and consultation to be an effective strategy of preventive intervention. A majority of those responding (89%) described the consultation process as helpful. In addition, specific teachers' behaviors were targeted for observational analysis indicating a need for improvement within some categories of teacher performance. Through case examples, it has been demonstrated that consultation in the classroom by mental health staff does impact on the relationship between the teacher and the child by promoting the teachers' understanding of child development, training the teachers to successfully deal with emotional and behavior problems, and by promoting positive mental health in the classroom.

Chapter 9

PARENT EDUCATION AND INVOLVEMENT

Overview

While parent involvement has been an important facet of Head Start, recent data from the Synthesis Project (McKey, 1985) shows conflicting results regarding Head Start's impact on parents. In general, parents value the Head Start experience, participate in the program in various ways; and in some cases, the experience helps to change parent's attitudes toward their own lives. Nevertheless, data does not tell us if parental involvement in Head Start is related to a child's performance on tests of cognitive ability or if Head Start brings about changes in child-rearing practices. Further, it is not clear if training parents to teach their children has an effect on parents or children.

The purpose of parent education and social support serves to enhance the potential for parents to become involved with LACA Head Start activities. A fundamental objective was to provide training to parents in parenting skills and child development in order to reduce the potential for high risk and to increase parent participation in order to provide social support and enhance coping mechanisms within Head Start families. Activities planned by the organizers of the MHP/IP study were designed to help meet these objectives and included: parent education sessions, family nights, intensive parent education/staff training and parent support groups. A comprehensive low cost parent education program was designed for the MHP/IP. Though the MHP/IP under the mental health component made this initial plan for parent education with the approval of LACA's administration, when it came to implementing the actual program, the Parent Involvement component, with the support of the administration, designed and implemented their own plan for parent education.

Parent Education and Participation

The following was the original plan for parent education: Parent education sessions were to be accomplished in clusters where parents from two or three sites would meet together at one location with the initial training providing two sessions for each parent cluster. Prior to the parent training, all LACA (supervisory and support staff) were to be given the same training. The objective of such training was to introduce all staff to the quality and content of the program. The expected outcome was to be broad parent participation in the training, supported and encouraged by all staff (teachers, social workers, and parent involvement aides). Bimonthly family nights were designed to provide a forum for information/education/questions on parenting for adult family members as well as supervised play activities for children.

An intensive parent education/support staff training was to be conducted in November, 1984. Those in attendance would include parents who wished for additional information/training following the initial parenting sessions, as well as social workers and parent involvement aides who would work directly with the parents. Parents who completed the intensive training would also comprise the parent-to-parent networking volunteers who could support other parents through classroom/site sessions. In this effort, they were to use a specially developed series of four video tapes of parenting sessions from which to provide the foundation for a social support network for parents.

Overall, the activities were focused on parents who were not already involved in the program. That is, activities were not geared to parents who were already involved in LACA's parent advisory boards. Because funding did not begin until September, 1984, and because the focus of the MHP/IP Project was to initiate the needs assessment of the population, activities related to parent education and involvement did not begin until March. It was, in part, the late beginnings, as well as the lack of priority given to parent education and involvement within Head Start by LACA's administration that ultimately affected this aspect of the MHP/IP Project.

The rest of this chapter will, in descriptive form, discuss the activities that took place and the problems in realizing our objective.

Family Nights

This activity provided a forum for information, education, and questions on parenting for family members as well as supervised play activities for children. It was an opportunity for parents to obtain further information which would benefit them as the primary educators of their children. Organized by the Parent Involvement component, family nights were considered to be more of a supplement to the parent education sessions discussed below.

The activities which were scheduled for parents reflected ideas generated by the parents through group discussions. The first Family Night, for example, saw a presentation by an MHP/IP staff member on the importance of parent involvement. Generating questions from the parents allowed for the development of topics such as child discipline, health, and child development, which could be incorporated into the family night forums.

This was followed by a presentation on the necessity of quality health care for pre-school children and providing low-income people with information on available resources to help them obtain that care. The presentor was a health specialist from a health care center. It was an important aspect of the family nights to present such a speaker since parents had actively asked for more information in this area.

The major presentation within the family night format addressed child development. The presentors were child development specialists who had actively directed the parent education sessions. Their coming to family nights allowed parents to follow-up on the presentations they had attended for the parent education sessions.

There were, however, a series of problems which halted the attempts to make family nights a successful forum for parents. For one, attendance was usually sparse. Family nights, when scheduled, took place at two locations and on alternate weeks. Each location was picked on the basis of geographical proximity to parents. Since the San Fernando Valley is such a large area and transportation is a problem for some parents; one site addresses those parents who live in the East Valley while the other site does the same for parents in the West Valley. Yet, despite formal invitations to parents, attendance was small. In retrospect, it seems that having more family nights in more accessible locations might have increased attendance.

Parent Education Sessions

These sessions were to be conducted by a parent educator with parents from the entire project. Sessions were held at each site with most parents attending. In addition a staff (supervisor and support staff) training session was held to orient them to the training parents were to receive. The expected outcome of these sessions was to have been increased parent participation. The focus of the sessions was child development (appendix 5).

An objective of the training was to improve parenting skills. Issues explored in these sessions dealt with understanding child development by focusing on the findings of Piaget and Erikson, and addressing such topics as identifying important aspects of emotional health in children and the importance of play. In addition, issues such as separation anxiety, conflict management and problems of being a parent were also addressed. From this perspective, the role of parent values in influencing early socialization would "provide the infant or young child with practice in culturally appropriate social and emotional behavior (Super and Harkness, 1982:9)."

The sessions were held at each Head Start site and the parent educators reqported their work to have been successful based on parent response to the activities. The focus of the training, conducted bilingually, was to familiarize parents with the development of the young child and thus enhance their social competence by providing strategies in self-help, problem solving and communication skills. Parents felt that this type of training was the most exciting activity they participated in during the school year. Basically, they felt there was an extreme need for parent training. There was a feeling among parents that without a working knowledge of child development their ability to understand children's needs would be hampered. The most asked question from parents was why is this type of training not held on a regular basis?

Still, two problems marred the complete success of these activities. First, the parent educators were not hired by LACA management until the end of January, 1985. The original plan was to hire the parent educators by September so as to complete the parent education sessions by the end of the year, thereby concentrating time in the winter to developing intensive parent education sessions for those parents who wanted more training, and the development of parent support groups at each site. As it stands, the parent educators did not officially begin their work with parents until March 1, 1985 with one session per week at each site. This schedule took the educators well into the month of May. Naturally, by that time the school year was coming to a close and time for intensive parent education sessions and the development of parent support groups was just not available, and thus, were never achieved.

In sum, there were many reasons for the parent activities not being successful. No one individual can be blamed for this lack of success. There were some important lessons which were learned however. Parents want to be involved, and not just with arts and crafts as is viewed by a select group within the Head Start program. When given the opportunity to express their concerns, sentiments, and criticisms, it becomes obvious that parents are very concerned with the education of their children. As primary educators, they are anxious to improve their skills and would be willing to participate in activities that, in fact, increase their social competence as parents.

The problems encountered by the MHP/IP project are based largely on the system's attitudes towards parents as well as an unclear picture of what is expected from parents. These ideas and criticisms will be further developed in Chapter 12.

Chapter 10

IN-HOUSE MENTAL HEALTH TREATMENT SERVICES

Overview

This chapter presents the findings for in-house mental health treatment services delivered through the MHP/IP. Included in this section are: (1) data on the demographic characteristics of Head Start families; (2) the identification of treatment needs; (3) treatment characteristics of services delivered; and (4) outcome evaluation of in-house mental health treatment services.

LACA enrolled 960 children for program year 1984/1985. The mental health component received 199 referrals on these children and families representing 21% of LACA's total population. Of these 199 referrals, 121 (13%) received treatment. For purposes of this study, treatment has been defined as the stages from preliminary interview and beyond. Of the 78 cases that did not receive treatment, some received teacher and parent education.

When a comprehensive mental health program provides for prevention, early identification, and intervention, the children and families in need of services will likely be identified. By providing the needed mental health services to these children and families, the potential for long range damaging psychological and developmental disturbances will be reduced.

In reviewing the ethnic background of families and in contrast to much of the literature, which has indicated that high risk populations do not utilize mental health service, the MHP/IP demonstrated that when comprehensive, readily available, direct mental health services are provided, such a population will utilize them.

Of LACA's 960 children, 199 (21%) of the population were referred for mental health services. These findings are consistant with the literature which shows a high percentage of Head Start children need mental health services. This high referral rate contradicts the low referral rate in the rest of Los Angeles County Head Start where ½% of 2% of the children were referred to the mental health component and ½% of the children and families were referred to outside community mental health agencies. Is this reflective of the overall percentage of children and families who may be in need of mental health services; or is it that comprehensive mental health services have not been a priority in Head Start?

Demographic Characteristics

Ethnic Background of Families

Of the 199 children and families referred to the mental health component, an intake form was completed on 117 families. Data from this form reveal the following ethnic backgrounds (table 32): 59% were of Mexican/Mexican American descent, 15% Caucasian, 7% other Latino (Cuban, Guatemalen, etc.), 5% Black, 11% mixed ethnic background and 3% other ethnic groups (77% of LACA's population is Hispanic). The heterogeneity of the population was well represented in the treatment group.

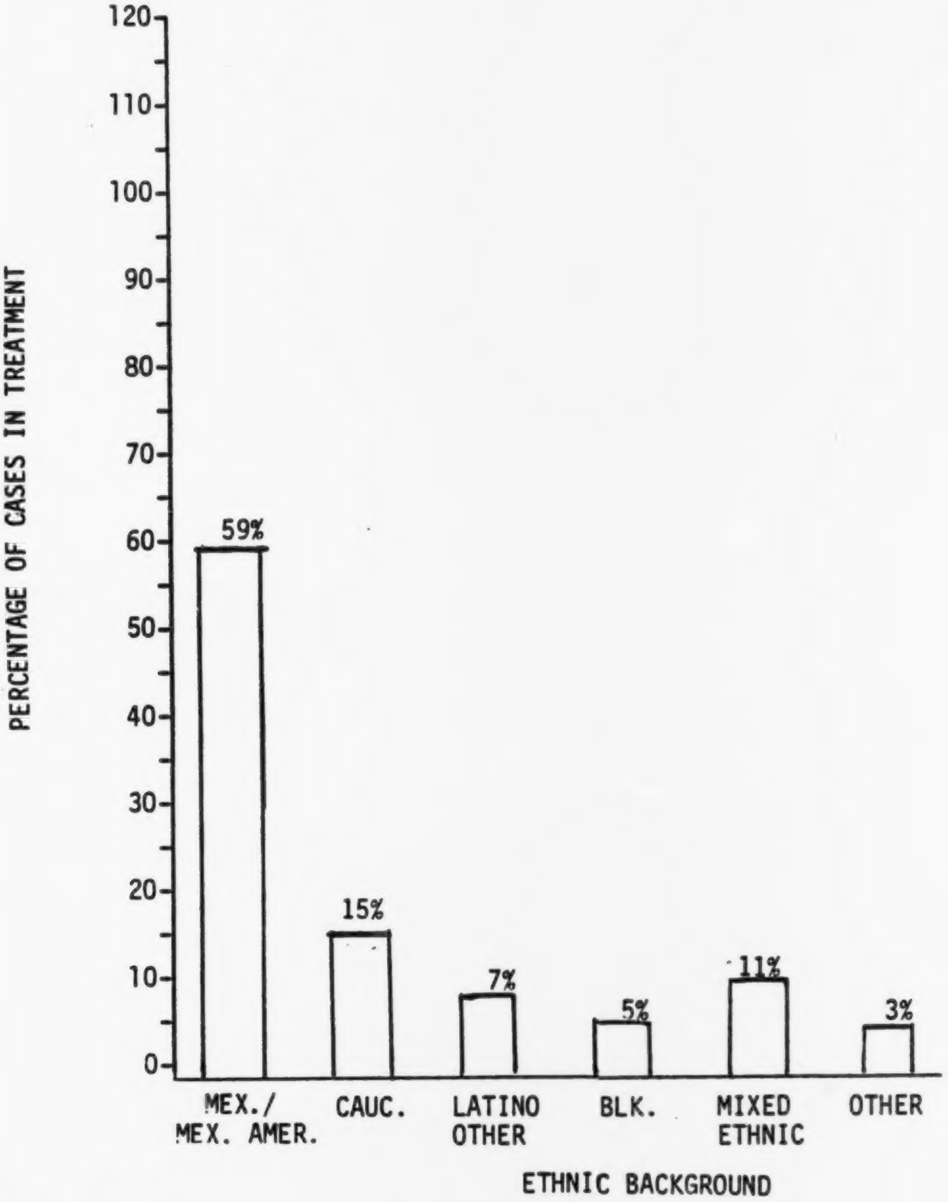
Language

Of the total number of Head Start families referred for in-house mental health services, 49% were monolingual Spanish-speaking and 32% reported being monolingual English. 17% of the population reported being bilingual, speaking both English and Spanish. Other languages such as Vietnamese and Arabic were represented by only two percent of the population. The high percentage of monolingual Spanish-speaking families pointed out the need for

Table 32

Ethnic Background of Head Start Parents Referred for Mental Health Services

(N = 121)

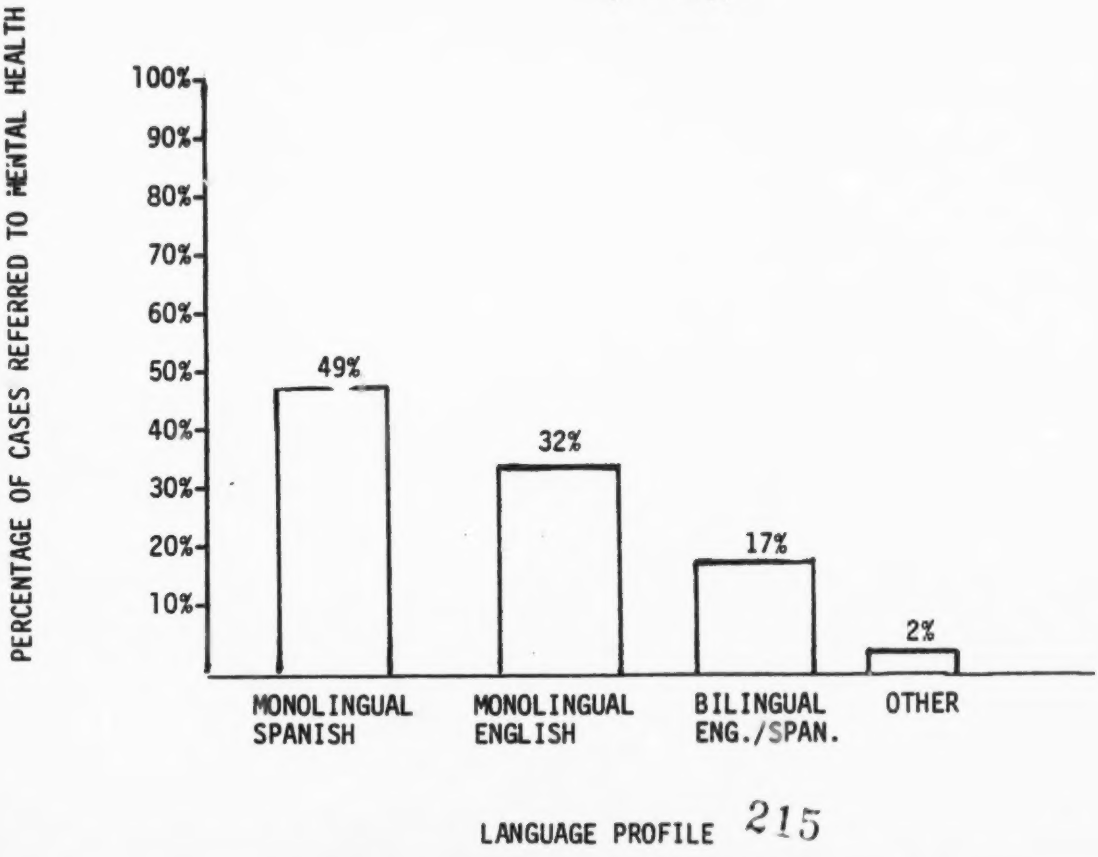


a bilingual counseling staff who would also be culturally sensitive to the needs of Latino clients. In Los Angeles County, 30% of the population is Hispanic but only 13% of the people using county mental health services are Hispanic (Los Angeles County Department of Mental Health, 1984). This low utilization is in contrast to the high utilization of mental health services by LACA's monolingual Spanish speaking families. This low level of utilization is in part due to the fact that children, families and minorities usually receive the lowest priority for funding. Also there is a lack of bilingual counselors. The MHP/IP employed bilingual and culturally sensitive counselors who demonstrated experience in working with low socioeconomic families and children (table 33).

Table 33

Language Profile of Head Start Families Referred for Treatment

(N = 199)



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Child's Caretakers

Beyond the language and cultural context of the family, children are most influenced by those who are responsible as the primary caretakers. In table 34, it is revealed over a half of the Head Start children (57%) reportedly live with both biological parents. The second largest group, single parent mothers, represent 26% of the population. The new family constellation of biological parent and significant other is represented by 9% of the total treatment population, while 8% of the children are reported to be living with significant others (e.g. grandparents, foster parents, etc.). Throughout this report the terms caretaker and parents are used interchangeably although in certain situations the caretaker is not the biological parent. Also, the terms mother and father are used to refer to female and male caretakers.

The data on the child's caretaker shows that 43% of the children are not living with both of their biological parents. This situation may reflect: 1) that the child has never lived with both of his or her parents and possibly does not know one of his or her parents, 2) the child's parents are separated or divorced, or 3) that one parent died. In most cases, it is the father who is absent from the home. These factors can lead to unresolved separation and abandonment issues. It has been shown that the absence of the father has been associated with increased problematic behavior in preschool children (O'Regan et. al., 1980).

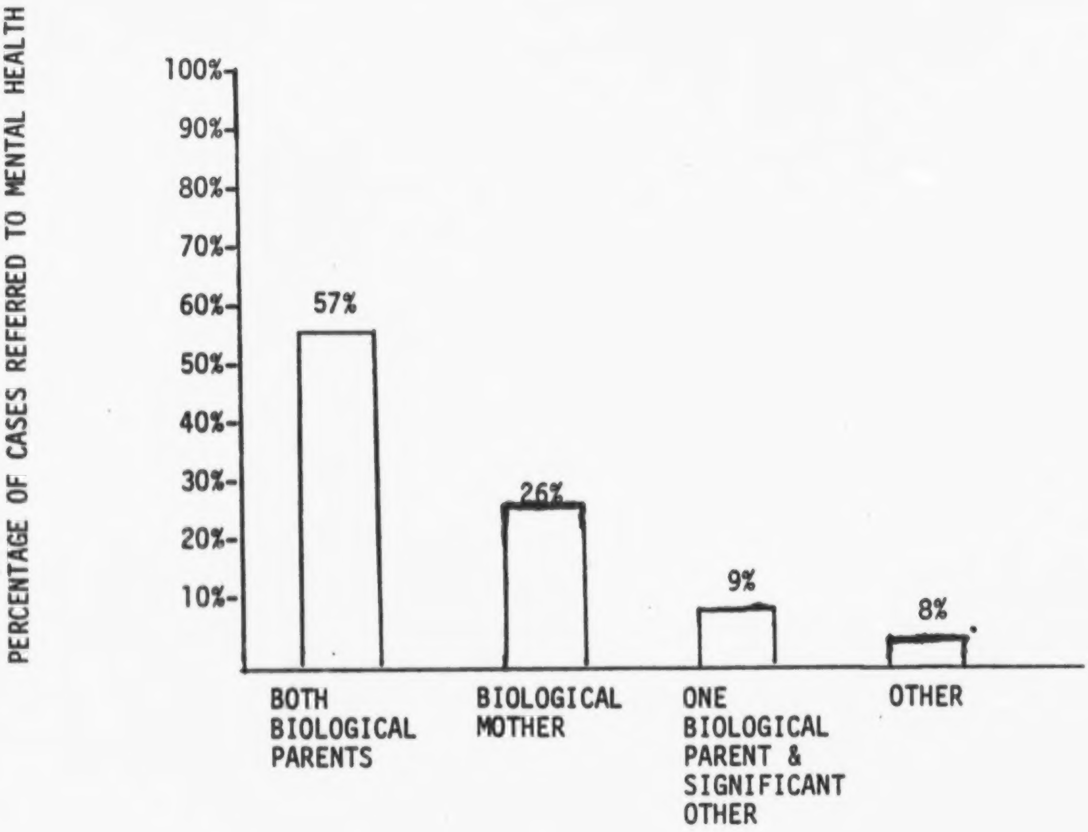
Income and Income Source

The majority of families fall within low income poverty level guidelines required by Federal regulations. Of the 117 intake forms completed, income was reported for 66 cases (60%). Of these cases, the income ranged from

Table 34

Head Start Families Reported as Child's Caretaker(s)

(N = 117)



CHILD'S CARETAKER(S)

$99.00 to over $600.00 dollars per week. The smallest range was reported by four (6%) families who reported earning less than $100 dollars per week (table 35). The majority of families report their weekly income to be between $100 to $399 dollars per week.

Sources of income derived from either employment or public entitlements. 121 families (60%) received their income through employment. However, the remaining 40% were on various types of public assistance (table 36). Of the 44 families receiving public assistance, 36 (29%) received Aid to Families with Dependent Children (AFDC), 4 (3%) received social security, and 4 (3%) reported receiving employment benefits.

Low income is one of the factors contributing to high risk as evidenced by 96% of LACA's children and families living well below the poverty level. 40% of the families treated were receiving some form of public assistance, mostly AFDC (82%). It has been demonstrated that poverty, substandard housing, unemployment, and poor nutrition all appear to increase the risk of psychopathology (Cohen, et. al., 1979). Longitudinal studies also show that a economically disadvantaged populace is at high risk, having a high incidence of child and spousal abuse, the highest probability of mental illness, repeated and prolonged mental hospital institutionalization, a high rate of juvenile delinquency, incarcerations, school drop-outs, broken families and alcohol and drug addictions (Morales, 1983).

Age Groups and Levels of Education

The age of parents receiving treatment ranged between the ages of 18 to 65 years. The average age of mothers was 31 years while the average age for fathers was 33 years (table 37). The distribution of age groups among Head Start parents in the treatment group appear consistent with LACA's population.

Table 35

Income Level of Families Receiving Treatment

(N = 66)

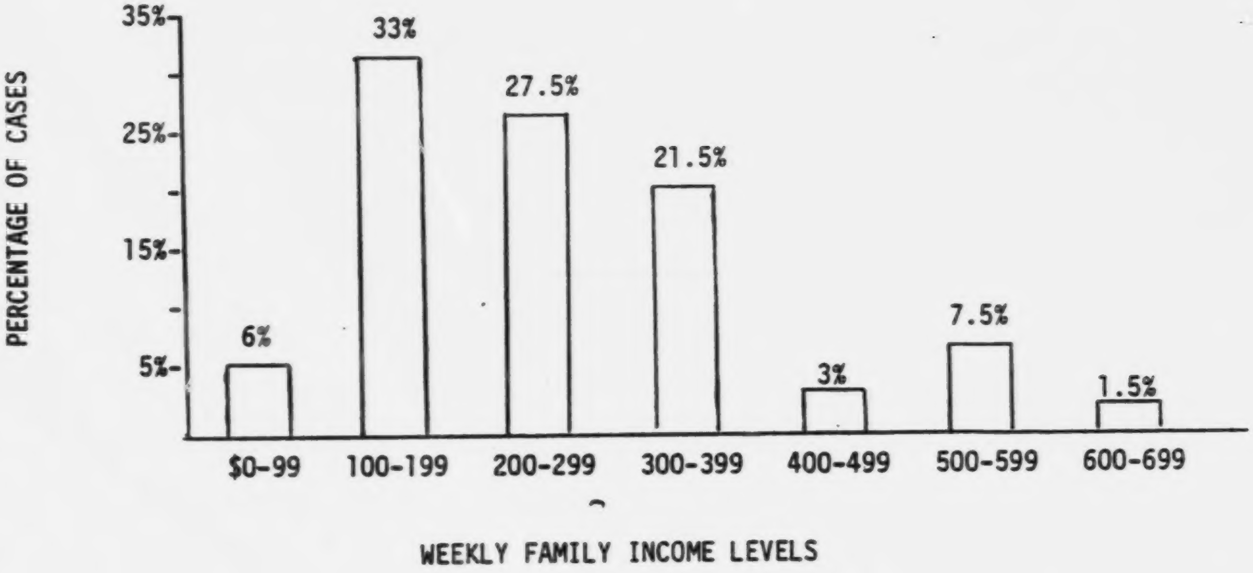
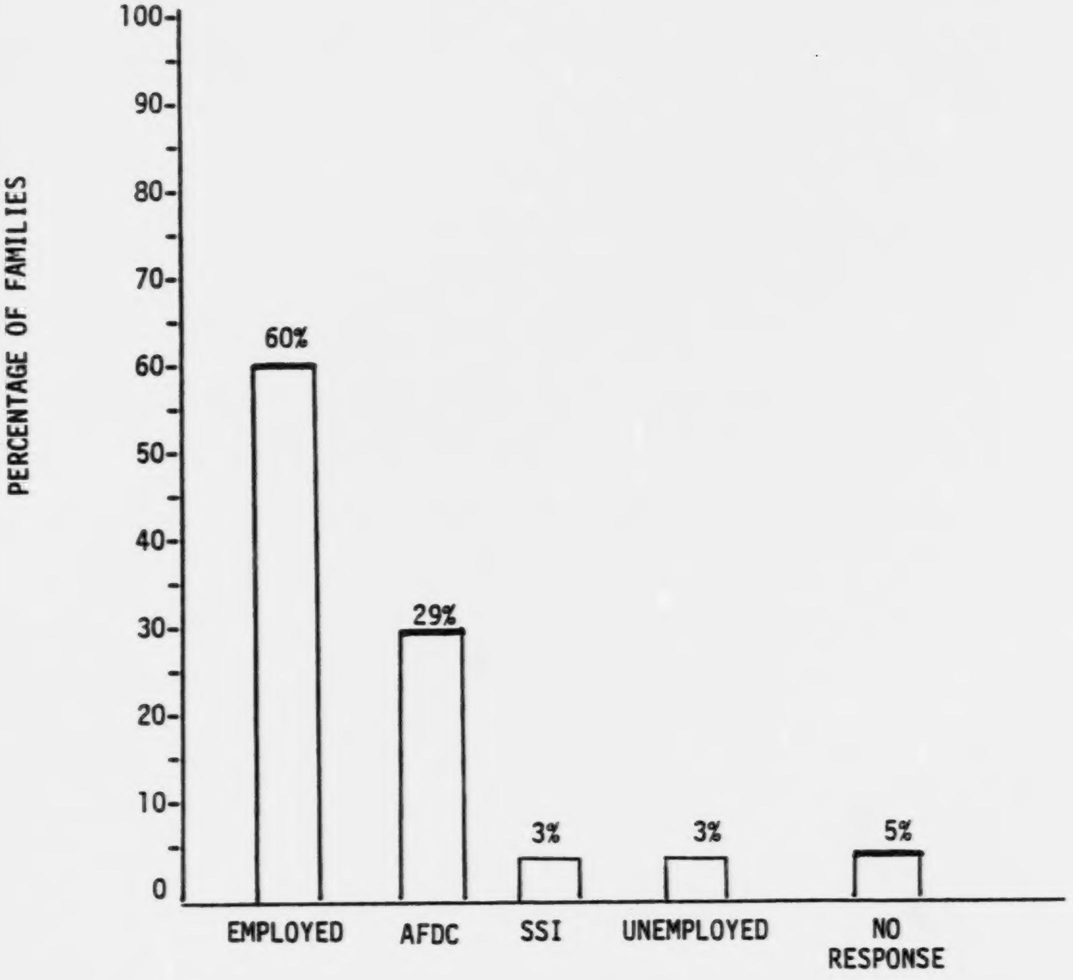


Table 36

Source of Income

(N = 121)

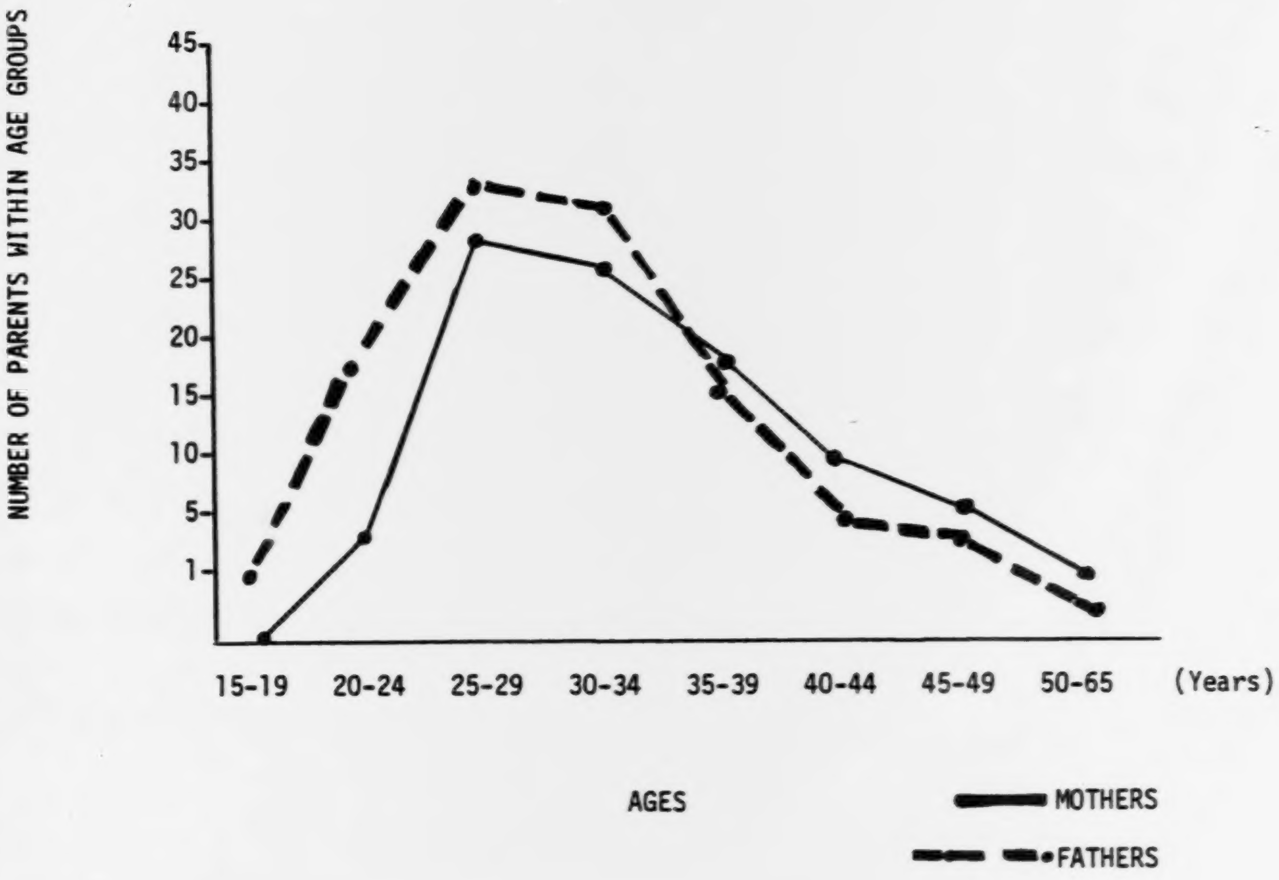


SOURCES OF INCOME

Table 37

Age of Mothers and Fathers

(N = 121)



It can also be seen that levels of education ranged from no schooling at all to graduate education. But these two extremes represent only a small fraction of Head Start parents. The average educational level for both parents was the 8th grade. Only 22% of mothers and 37% of the fathers graduated from high school.

For both mothers and fathers the average educational level was 8th grade, indicating that parents often lacked the formal education and necessary job skills that are needed to compete in the technological society in which they live. Many, in fact, only have an elementary school education (40 women, 34 men). Another large group only have a senior high school education (41 women, 26 men). The first group of parents had very little formal education, while the other group had a much higher level. It has also been demonstrated that a low educational level of parents often puts families at high risk (O'Regan, et. al., 1980).

A lack of English language skills, poverty, and a low educational level often cause people to feel inadequate and intimidated in utilizing existing social services, including mental health services. The MHP/IP was designed to build on existing strengths of families, not their deficits, regardless of the fact many did not speak English, were below the poverty level, and/or had little formal education. The MHP/IP viewed the parental relationship as the most important and critical relationship in the child's life. Parents were acknowledged and given the utmost respect in their role as the primary educators of their children.

Identification of Treatment Needs

Source of Referrals

Of the 199 children and families referred for mental health services, 72% were referred by the child's teacher, 20% by the parents, and 8% by the support staff. The high percentage of referrals made by the teachers was due to the fact the teacher had daily contact with the children and families. They received a detailed orientation towards the available mental health services and on-going training from the mental health staff. In some cases, it was the mental health staff or the Child Development Specialist (CDS) who first identified the problem and requested teachers make out a referral. 20% of the referrals were initiated by the parents which reflected the effectiveness of the mental health orientation in encouraging the parents to refer themselves. It is the authors' view that greater follow-through on treatment and less resistance on the part of parents would occur if more parents requested counseling services themselves rather than have the teacher initiate the referral.

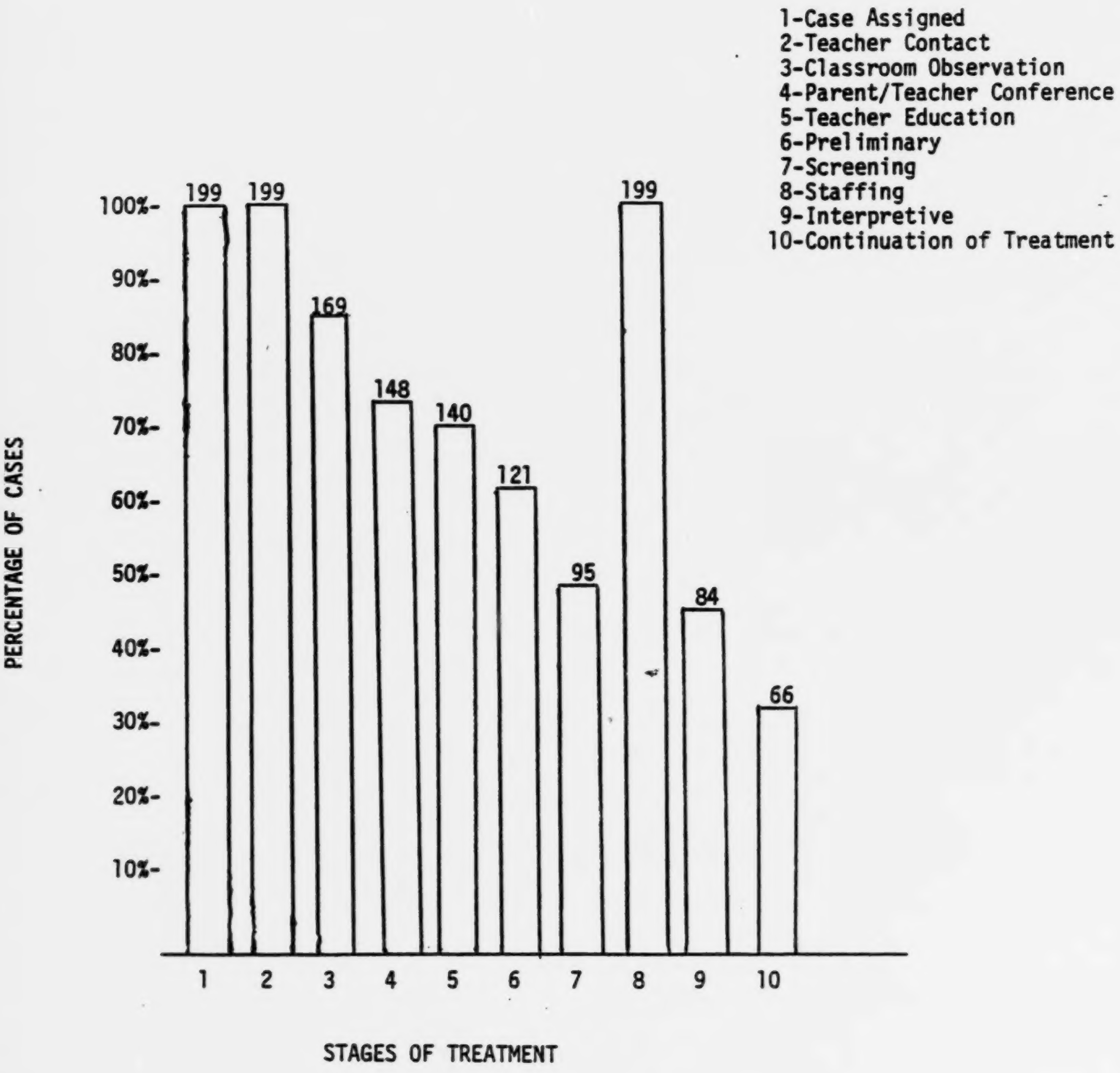
Stages of Treatment

Each case had the possibility of going through 10 stages of treatment (table 38). Each referral (199) was promptly assigned by the mental health specialist to one of the counseling staff. Next, teacher contact was made, followed by a classroom observation. 30 cases (15% of the total referrals) did not have an observation due to the following reasons: some of the referrals were on individual parents or siblings so that a classroom observation was not needed, some children had moved or dropped out of the Head Start program or the referral was inappropriate, (i.e., the child needed services from another component).

Table 38

Stages of Treatment

(N = 199)



148 cases (74% of the total cases) had a parent/teacher conference. 11% of the parents failed to attend the parent/teacher conference because they were working and were not able to attend during classroom hours. Others, although not attending the parent/teacher conference, did attend therapy sessions. Although in some cases teachers were effective in their communication about mental health, some parents were resistant to or refused services. In other cases, a trusting relationship had not developed between the teacher and the parent which may have caused the parent to feel uncomfortable discussing the problem with the teacher. This difficulty may have contributed to the unresponsiveness of some parents. However, it should be noted that in the majority of cases, teachers were successful in encouraging parents to attend the parent/teacher conference.

On the other hand, some teachers did not perceive parents as the primary educators of their children and at times viewed parents from a deficit model by not recognizing their inherent strengths. Further training is recommended to assist teachers in effectively interacting with parents. 83% of the cases reaching the classroom observation stage also received teacher education. Teacher education was important as an integral part of the coordination between in-house mental health treatment services and the classroom environment. As a result of this cooperation, teachers were able to assist the child in developing a sense of self-esteem and participation in his/her environment, thereby promoting the child's social competence. 82% of the cases participating in parent/teacher conferences moved to the next stage, teacher education.

Of the total number of referrals (199), 121 (61%) attended preliminary sessions. The preliminary session, attended by the child's parents alone, underscored the parents' role as the primary educators of their children. In some cases, treatment was completed at the preliminary stage, and the family did not need to continue counseling.

Of the cases attending the preliminary session, 79% continued to the screening session. At this time, the entire family was seen and the problem was discussed in the context of the whole family, and the pressure was shifted from the child who was the identified patient. The session supported the MHP/IP's model of treatment which does not view the child in isolation but instead works with the family as an integral unit.

The counselors saw a variety of responses from the families. Some families were responsive and verbal about their problems, and other families made a unified effort to present a problem-free situation where both parents and children denied the existence of any problems. This resistance was to be expected since so many of the families had never had any therapy and felt that personal problems should not be discussed with individuals outside of the family. As a result, counselors made a conscious effort to help the family feel comfortable. The counselors also addressed the stigma attached to having problems, and, in fact, recognized we all have problems at times. In some cases, all family members did not attend the screening sessions. One parent may not have attended and/or some of the siblings were absent. Treatment may have been completed at this stage.

It was program policy for mental health counselors to staff all of the cases with the mental health specialist individually or at the weekly staff meeting. A recommended treatment plan was made. If appropriate the child or family may have been referred to other components for adjunctive services. For example, a child may have been referred to the handicap component which would have arranged for testing of psychological, developmental, and/or learning problems. This coordination emphasized the multi-disciplinary approach to service delivery.

Of the cases that had screening sessions, 88% went on to have an interpretive session. The parent(s) alone attended this session, at which time a recommendation was jointly reached for treatment. At times, treatment may have been completed at this session. It is important to note that the interpretive session emphasized a team approach, where the counselor and parent(s) jointly decided on the course of treatment. The parents' social competence was promoted and a sense of self-esteem was nurtured. Parents gained a feeling of being active participants in the therapeutic process rather than taking a passive role. When the parents sense of individual responsibility was nurtured it increased the likelihood of successful treatment.

Of the 199 cases received by the mental health component, 66 cases (33%) had treatment beyond the interpretive session (referred to as continuation of treatment). 66 cases continued treatment and represented 79% of the cases that had interpretive sessions where a treatment plan was formulated by the counselor and parent(s). A significant percentage of cases completed treatment prior to, or at the interpretive session. In these cases, the counselor provided therapy to parents and families and worked extensively with the teaching staff in resolving the problem in the classroom. These problems were not severe enough to require continuation of treatment. In addition, there were cases in which the parents decided not to continue treatment. Some refused or were resistant, others had transportation problems or various other difficulties.

Treatment Characteristics

Of the total number of referrals received by the component, 150 (75%) had the original presenting problem on the child and 49 (25%) had the original presenting problem on the family. The original presenting problem refers to the reason for which the referral was initiated and it should be kept in mind, only the principal problem was calculated for purposes of these findings. In most cases, the teaching staff made the referral because an emotional and/or behavioral problem was exhibited by the child in the classroom. The predominant original presenting problems on the child were aggressive behavior, speech problems, age inappropriate behavior and separation anxiety. These findings are consistent with O'Regan et. al. (1980) who state the most prevalent problem of preschool children is hostility/aggression. The most predominant original presenting problems on the families were divorce, separation problems, lack of parenting skills, death, individual unresolved issues, sexual abuse, and marital problems.

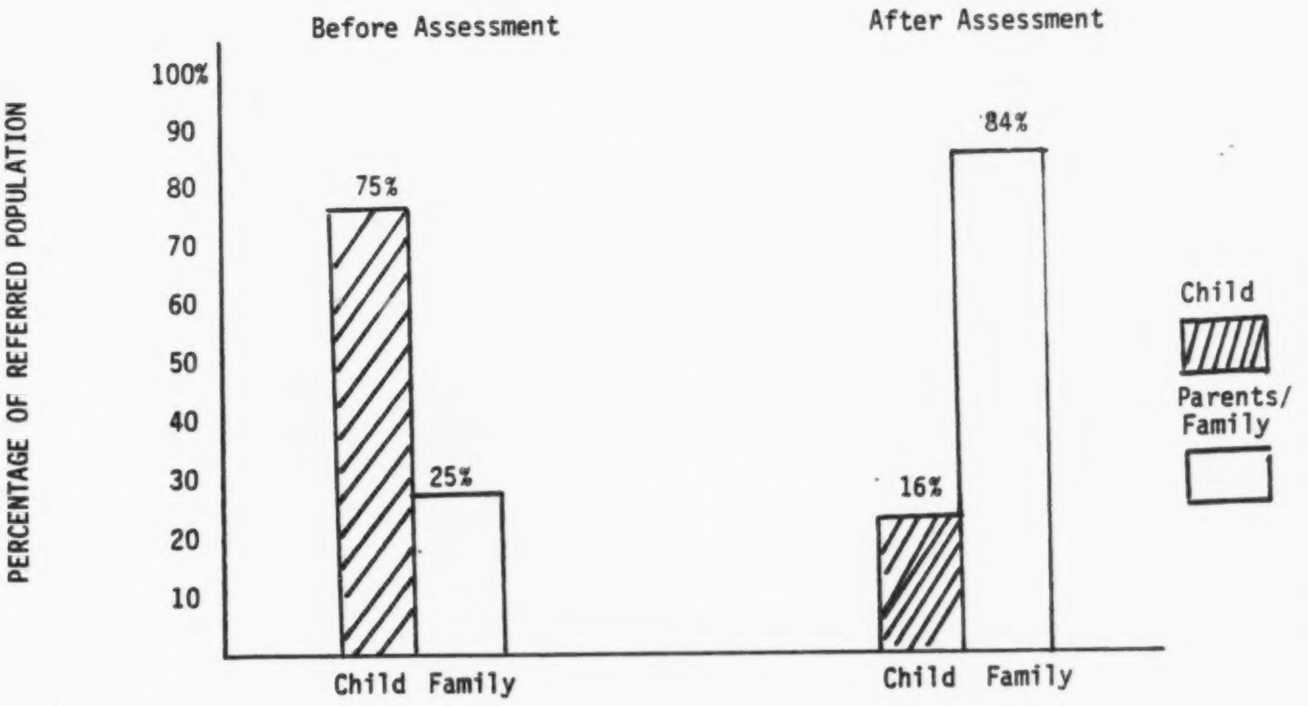
After the classroom observation, the parent/teacher conference, the preliminary and the screening session, the counselor was able to comprehensively assess the case and determine the cause of the problem. After the assessment, in 26 (16%) of the cases, the presenting problem remained on the child, and in 134 (84%) of the cases the presenting problem after assessment, was on the parents/family. 39 cases did not reach assessment.

The initial referrals addressed the manifested problems in the classroom. On the other hand, the MHP/IP model viewed behavior from the standpoint of cause and effect. The manifested behavior (symptom) that appears in the classroom is the effect. If the effect is treated alone, the origin or cause of the problem which could possibly lead to long range damaging effects will not be resolved. After assessment of the cases, there was a dramatic shift from child-centered problems to family-centered ones. Parent/family problems constituted 84% of the problems after assessment as opposed to the 25% prior to assessment. Now 16% of the referrals were on the child, whereas before assessment, 75% of the problems were on the child (table 39). 32 of the original referrals were for aggressive behavior (the most common original presenting problem). In 31 of these 32 referrals, the counselors discovered that after assessment the aggressive behavior was the result of a family problem. In 10 cases, it was due to lack of parenting skills; in 5 cases, individual unresolved issues of the primary caretaker; and in 4 cases, divorce, and separation. In most cases, the cause of the problem was due to disruptive and/or dysfunctional family dynamics, and the whole family, not the child alone, was in need of mental health services. Age inappropriate behavior was also one of the most frequent reasons for referral of children (22 referrals). However, after assessment, it became evident the child's difficulty was due to a lack of parenting skills, individual unresolved issues, or divorce and/or separation of the parents. Individual unresolved issues consisted of the parents, foster parents, and/or the primary caretakers having to resolve some of their own individual problems which affected the child, and in most instances, the family. If the original presenting problems had been treated, then the child would have become the identified patient and the origin of the problem (i.e., parent/family problem) would not have been resolved. These original presenting problems (e.g., aggressive, non-responsive and age inappropriate behavior, etc.) had the potential for becoming serious psychological and developmental disturbances if prevention, early identification and intervention had not occurred. (See table 40 for comparison of original

Table 39

Presenting Problem Before and After Assessment

(N = 199)



REFERRED CHILDREN AND PARENTS/FAMILY

presenting problem and problem after assessment).

In a number of cases, speech and developmental delays remained the target problem after assessment. In 21% of the referrals for speech, the problem after assessment remained a speech problem. In 31% of the referrals for developmental delay, the problem after assessment remained one of developmental delay. In these cases, the child was treated and an appropriate referral was made to an outside community agency (i.e., Regional Center, etc.) for adjunctive services.

After assessment, 5 of the 15 cases with the original presenting problem of separation anxiety were now, after assessment, a result of individual unresolved issues; 5 of the 32 cases with the original presenting problem of aggressive behavior were now, after assessment, a result of individual resolved issues, and 4 of the 22 cases of age inappropriate behavior were after assessment, a result of individual unresolved issues.

In the MHP/IP, lack of parenting skills included a parents' inability to express to and receive love from their children, nurture self-esteem in their children, appropriately discipline their children and/or provide a parental role model. These lack of parenting skills do not, in and of itself, constitute diagnosible pathology, but it is clear to see that if these problems continue untreated they could increase the potential for pathology in the children.

This data has verified the need to shift the orientation of early intervention programs, in particular Head Start, which has historically focused on the child alone, to an orientation emphasizing service to the whole family as an integral unit (see HHS, 1980). The MHP/IP's emphasis

Table 40

Comparison of Original Presenting Problem and Problem After Assessment

			AFTER ASSESSMENT																						
			CHILD										PARENT/FAMILY												
		original presenting problem	separation anxiety	aggressive behavior	withdrawn behavior	non-responsive behavior	short attention span	depression	speech	developmental delay	age inappropriate behavior	other	marital problems	separation/divorce	lack of parenting skills	death	systemic dysfunctional communication	domestic violence	drugs	child abuse/physical	child abuse/sexual	individual unresolved issues	alcohol	other	N/A
BEFORE ASSESSMENT CHILD	separation anxiety	15	•••	•										•	•		••	•				•••••			1
	aggressive behavior	32											•••	••	••••••••••	•	••			•		••••		•	8
	withdrawn behavior	13											•	••	••		••			•		•••••			-
	non-responsive behavior	13																				••••			2
	short attention span	5					•							•				•		•					1
	depression	1						•																	-
	speech	23			•				•••••	••••			•		•••		••		•			•	•		4
	developmental delay	13								••••					•		••••					•			3
	age inappropriate behavior	22								•			•••		•••••				•			••••			8
	other	14										••••	•		•		•••					•			4
BEFORE ASSESSMENT PARENT/FAMILY	marital problems	5											•••	•										•	-
	separation/divorce	7												••••••								•			-
	lack of parenting skills	6													•••••							•			-
	death	5														•••••									-
	systemic dysfunctional communication	3													•		••								-
	domestic violence	3																•	•						2
	drugs	3													•		•								-
	child abuse/physical	2																		•	•				-
	child abuse/sexual	5						•													•	•		•	1
	individual unresolved issues	5																				••••			1
	other	4																							4
	Totals	199	3	1	1	0	1	2	5	9	0	4	11	13	37	6	18	3	3	4	2	33	1	3	39

on the ecological approach has the potential to enhance Head Start's affectiveness as an early intervention, family-centered program, allowing Head Start to reach its primary goal for both the child and the family - the promotion of social competence.

Treatment Interventions

4 types of therapy were provided: family, individual, conjoint and/or play therapy. A total of 627 sessions, with an average of 5 sessions per case were provided. 47% of the sessions were for individual therapy, 26% for family therapy, 16% for conjoint therapy, and 11% play therapy. Most cases included a combination of modalities, for example, a case with 5 sessions may have included two family therapy sessions, two individual sessions and one conjoint session. This approach was reflective of the MHP/IP's ecological orientation.

There were a number of reasons for the high percentage of individual sessions. In many cases, a parent had their own individual unresolved issues and, therefore, individual therapy was the most appropriate modality. For example, in one case the original presenting problem was on a child for aggressive behavior in the classroom. After assessment it was determined the main cause of the child's aggression was the father's insensitivity and lack of warmth towards his family; he physically abused his wife and had minimal interaction with his 4 year old son. He came from a disruptive family where his parents separated when he was very young, he was physically abused as a child and did not have an appropriate parental role model. As an adult, he had a low sense of self-esteem, he was angry for having fathered a child out of wedlock as an adolescent and for, as a result, having to get married. In short, he did not want parental and family responsibilities, and as a result, was insensitive and refused to emotionally participate in the family. In cases like this where individual therapy was necessary, treatment consisted of assisting the individual to resolve his unresolved issues and to assist him in the intergration of the family by developing effective communication and effective problem solving skills.

Another reason for the high number of individual sessions was due, in some cases, to parents refusing conjoint or family therapy. In these situations individual therapy took place with the willing parent. Of the total number of sessions that occurred in intact families, 37% of those sessions were attended by both parents and, in 71% of the cases, counselors were successful in getting both parents to attend therapy at least once.

On the other hand, MHP/IP focused on treating the problem from the standpoint of cause and effect. Emphasis was not placed on the child as the identified patient which accounts for the low percentage of play therapy sessions (11%). Play therapy was provided for the child in those cases where the problem had a long duration and tertiary prevention (remediation) was needed with the individual child. The MHP/IP's orientation was to treat the entire family. As mentioned, some problems were encountered in getting both parents and/or the entire family in for treatment (see Appendix 6 for case summaries).

Table 41 gives a breakdown of what occurred to mental health referrals. 19 children (9%) dropped from the school program before the referrals were received. 121 children/families (61%) received treatment. In 11 cases (5%), the presenting problem was resolved before the initial contact. In 41 cases (21%), the parents refused or were resistant to treatment. In 7 cases (4%) the referral should have been made to another component.

Table 41

Status of Referred Head Start Families Identified for Treatment Interaction

(N = 199)

Status of Referral	Numbers of Families Referred	
Children dropped from school program before referral received	19	9%
Children/Families received treatment	121	61%
Presenting problem resolved before initial contact	11	5%
Parents refused/resistant to treatment	41	21%
Inappropriate referral (e.g., should have been referred to another component)	7	4%
Total	199	100%

Of the 199 referrals, 78 or 39% did not receive treatment. It is important to look at the cases that did not receive treatment and find ways to decrease this number so that the children and families in need of services may receive them. In 21% of the total number of cases the parents were either resistant or refused treatment for reasons which included: denial the problem existed, negative attitudes about mental health which were not able to be overcome, the refusal of one parent of an intact family to participate in treatment and who then strongly discouraged the other parent and family members from coming to therapy. In a few of these cases, teaching staff were resistant to cooperating with the mental health staff also due to a denial that the problem existed, and/or negative attitudes towards mental health which were not able to be changed. At times some teachers felt they had "failed" as teachers if a child was having problems in the classroom or some felt their workload was so demanding that they did not have the time to devote to each child in need of services.

In 5% of the cases, the presenting problem was resolved before the initial contact, and in 4% of the cases, the referral was inappropriate. When presenting problems are resolved before initial contact it is usually because the problem is not severe enough for a referral. Inappropriate referrals can be reduced by educating the teachers on a more intensive assessment of the problem before they make the referral as well as by training the staff on the appropriate services and responsibilities of each component. 9% of the children left the program before the referral was received. Since these children were referred to mental health they were most likely to be in a very high risk group and therefore in dire need of services. If the various components had been able to communicate with the family and stress the importance of keeping the child in the program, the child's leaving might have been avoided. If the components had been able to work more effectively as a team, families who had been resistant to counseling might have received assistance.

The length of treatment (from the date the case was assigned to the mental health counselor to the date the case was closed) ranged from 1 to 33 weeks, with a mean of 11 weeks. There was a total of 991 appointments made of which 627 (64%) resulted in sessions; 184 (18%) resulted in cancellations and 180 (18%) resulted in no shows. Of the total 627 sessions held, the number of sessions per case ranged from 0-32 sessions with a mean of 5 sessions per case.

Outcome Evaluation of Mental Health Services

In order to measure treatment success, a final review was completed on all cases. Three different sources were used in evaluating the success of treatment: the counselor, the teacher, and the parents. The counselor assessed whether the treatment goals had been successful in resolving or reducing the problem. The teaching staff was asked to evaluate success based on the resolution of the child's problem in the classroom. The parents were asked to evaluate the resolution of the problem within the context of the family.

There are several ways in which to evaluate the success rate of treatment such as psychological testing before and after treatment, changes in grades and academic performance, changes in behavior, and accomplishment of treatment goals. Because of the MHP/IP's orientation, it was decided success would be evaluated by determining if, in fact, treatment goals were accomplished, and if a significant change had taken place in the home and in the classroom.

The success of treatment was evaluated for two different groups. The first analysis was based on the total number of referrals received by the mental health component (199). The second analysis was done on the 121 cases who actually received treatment services (preliminary and beyond). A comparison was made showing the significantly higher success rate for those families who came for treatment.

Based on the sample of 199 cases, among the counselors, teachers, and parents, there was a consistant assessment of success rates. Counselors reporting 59% success rate, teachers 58% success rate, and parents, a 61% success rate. Lack of success was reported on 10% of the families by counselors, 11% by teachers, and 12% by parents. The remaining cases were not able to be evaluated because the child had dropped the program, the presenting problem was resolved before time of initial contact, or it was an inappropriate referral. These figures, averaging about a 60% success rate, are relatively high, especially in light of the high risk population which was served and the severity of family and child problems that existed. This high success rate demonstrates the effectiveness of in-house mental health treatment services.

The final review on all 199 referrals (see table 42) received by the mental health component showed the following:

(1) Parents: In 121 cases of 61% parents reported that treatment was successful, 24, or 12% said treatment was not successful and in 52 cases or 27% the final review was not applicable (see discussion).

(2) Teacher: In 115 cases or 58% teachers said that treatment was successful, in 22 cases or 11% treatment was not successful, and in 62 cases or 31% the final review was not applicable; and

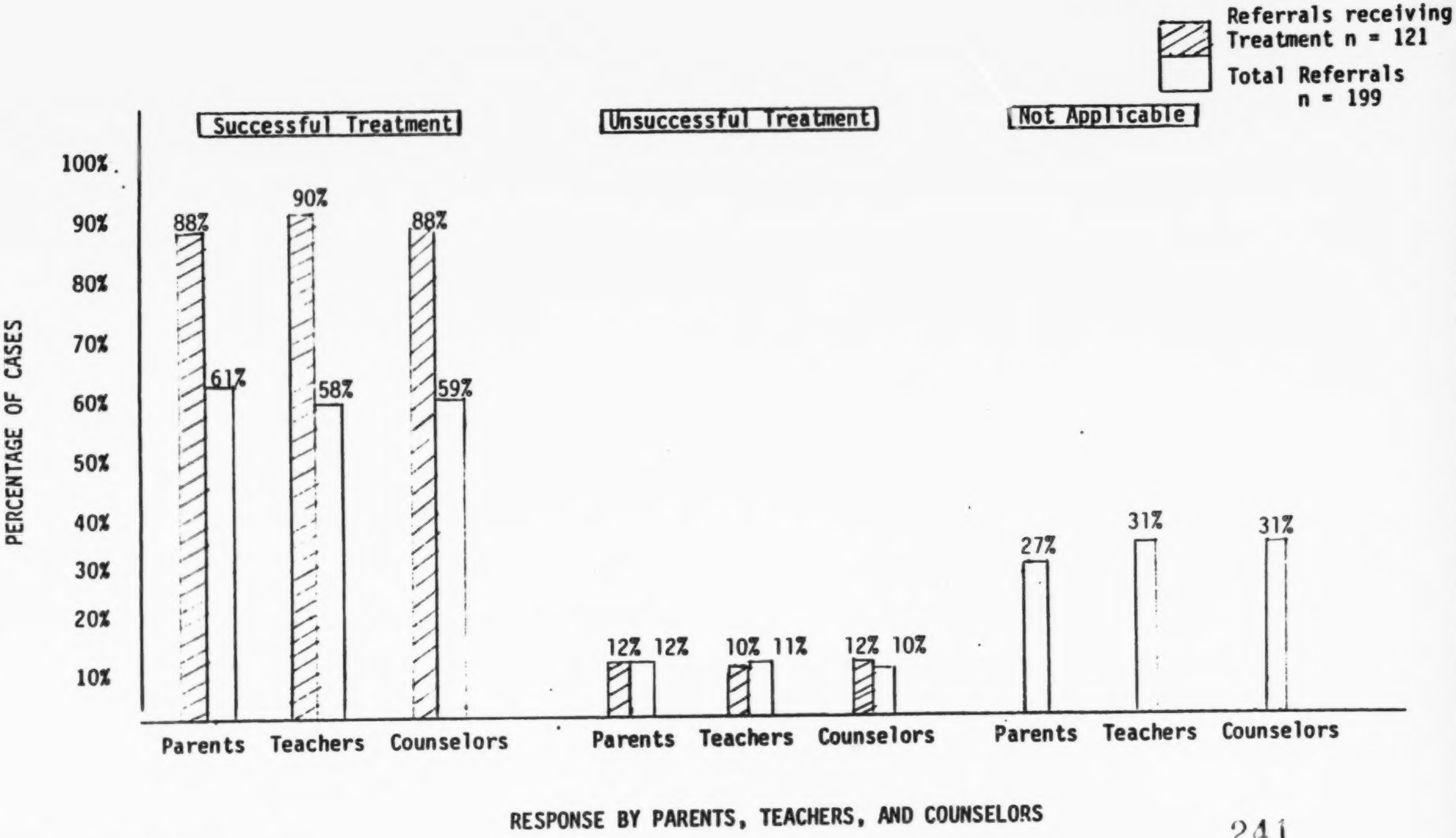
(3) Counselors: In 118 cases or 59% the counselors reported that the treatment was successful, in 19 cases or 10% treatment was not successful, and in 62 cases or 31% the final review was not applicable.

The final review on the 121 cases that underwent treatment showed the following:

(1) Parents: In 107 cases (88%) parents reported that treatment was successful, and in 14 (12%) reported treatment was not successful;

Table 42

Final Review/Comparison of Treatment Outcomes based on Parents, Teachers, Counselors Evaluations



(2) Teachers: In 109 cases (90%) teachers reported that treatment was successful, and in 12 (10%) treatment was not successful; and

(3) Counselors: In 107 cases (88%) counselors reported that treatment was successful and in 14 (12%) treatment was not successful.

64% of the appointments scheduled resulted in sessions which was a very high follow through rate for treatment with a low income high risk population; only 18% of the appointments resulted in cancellations, and another 18% resulted in no shows. The number of sessions per case ranged from 0-32 sessions with a mean of 5 sessions per case. Leventhal and Weinberger had similar findings showing a 77 percent improvement rate for children in a brief family therapy averaging 5.2 sessions (in Children's Defense Fund, 1982).

Table 43 shows the relationship between who the child lives with and whether treatment was successful (of the 121 cases that received treatment services). This data demonstrates no significant difference with success rates in relation to who the child lives with. Whether the child lives with both biological parents, one biological parent and a significant other, or a single parent mother, there is the same possibility of success in treatment. The literature shows single parent families have additional stress and therefore a greater potential for high risk. But the MHP/IP found that regardless of the family composition, these groups can, through treatment services, resolve their problems.

There were a number of factors contributing to the high success rate of treatment services. First, the MHP/IP provided direct, comprehensive, in-house mental health services. The parent orientation held at the beginning of the year and the emphasis on a family's inherent strengths, presented a

Table 43

Child's Caretaker and Success Rate of Treatment

Who the child lives with:	% who had successful treatment (N = 121)	% who did not have successful treatment (N = 121)
Both Biological Parents	89%	11%
Biological Parent and Significant Other	83%	17%
Biological Mother only	85%	15%
Other	89%	11%

safe and supportive atmosphere for exploring mental health issues through therapy. Second, the MHP/IP openly addressed the stigmas connected to mental health and how these stigmas had, in many instances, caused the community not to take advantage of mental health services. LACA's Head Start classrooms provided an entry point for assistance to high risk families. During the implementation of the MHP/IP, the authors' observed that parents brought their children to school, seeking a "head start" which would enable their children to succeed when they entered public school. As parents became involved in the program, they were likely to gain confidence in the teachers, the organization and themselves. They learned about the available support services - health, social services, handicap, parent involvement, and mental health - and how these services could benefit the entire family along with the enrolled Head Start child. They now had access to, and it appears they developed trust in, a community provider of mental health services.

A third factor contributing to the success of the MHP/IP was the team approach. The counselor and parents, together reached a plan for treatment services, thus allowing the parent to feel like an integral part of the treatment process. The counselor coordinated services between the teacher and parent so a consistency in nurturing an emotionally supportive environment existed in the school and home. The counseling staff contributed greatly to the success of treatment. Counselors were bilingual and had a knowledge of and experience with the different ethnic groups that made up LACA's high risk population. The counseling staff had extensive experience with preschool children and families and either were completing or had completed graduate school in psychology or related fields, and were working on hours for their clinical licensing exam. Even though each counselor had a high case load

(40 cases per counselor), there was sufficient time to effectively follow-through on each case. The counseling staff was highly committed to getting their clients to come for therapy, and worked evenings so working families would have the chance to attend therapy. For the most part, there was very little waiting time before families were seen for therapy. On the other hand, at many local community counseling agencies there is a one to three month waiting list. There was a deep sense of family love and commitment in the population served by LACA which was reflected in the results of therapy. The MHP/IP offered a unique situation because it not only identified children and families in need of mental health services but also offered in-house treatment.

It was the concern of some Head Start administrators and staff that parents would feel these services would be very intrusive in their lives and as a result, would have refused or been resistent to treatment. But, in fact, this was not the case and the high success rate demonstrates the effectiveness of the MHP/IP's approach.

Summarizing the above mentioned factors that contributed to the overall success of the MHP/IP, it can be concluded that this program provided an innovative approach to mental health service delivery to a high risk population within the context of a preschool program.

Parent Evaluation of Mental Health Services

In June, 1985, the mental health counselors contacted a sample of parents who received treatment in order to have them evaluate the services of the mental health component. Of the 121 families who received treatment, 78 of the families were able to be contacted. The parents were told by their counselor that another counselor would be contacting them for the evaluation so that they would feel free to give honest responses. The following are the questions and responses:

1. Do you feel the treatment provided by mental health has been of help to you?

YES	72	NO	4	Undecided	2
	92%		5%		3%

2. What things helped you the most in counseling?

   - Counselor's understanding and presence
   - Counselor's advice regarding child rearing and marriage
   - Learning better communication skills
   - Resolving personal issues
   - Resolving marital relationship

3. Was the therapist helpful?

YES	73	NO	1	Undecided	4
	94%		1%		5%

4. What things did you not like about our services?

   - Distance (suggestions of providing bus service)
   - Should start therapy earlier
   - More parenting skills during the day in English
   - Have family therapy with children
   - Have therapy with child and not with the family
   - Time inconvenient for husband
   - Should be available to all schools
   - Keep up program - helping very much
   - Push people to come to therapy
   - More courteous reception when arriving at office

5. Are there any suggestions you have that can be of help to us in making our services better this coming year?

YES	18	NO	60
	13%		87%

The parent evaluation of mental health services asked the parents if treatment was helpful to them and their family and was the therapist helpful. 92% of the parents felt that treatment was helpful while 94% felt the therapist was helpful. This is a slightly higher percentage then was reported in the final review where 88% of the parents felt that treatment was successful. In some cases, the treatment goals may not have been successfully or completely accomplished, the parents may have had some difficulty in accepting this. Parents consistently felt that treatment increased their sense of self-esteem, developed their communication skills and assisted them in resolving personal, marital and familial problems, thus promoting their social competence. The MHP/IP's effect on the lives of these children and families may be the first step in the realization of change that can occur when services are accepted and fully utilized.

SECTION III

DISCUSSION AND RECOMMENDATIONS

CHAPTER 11

STAFF TRAINING AND CONSULTATION

Overview

In this chapter, staff training and consultation is discussed. The findings from Chapter 8 are interpreted and recommendations for future program development are also presented. The following four areas of staff training and consultation are discussed: (1) mental health classroom observation/supervision cycle; (2) teacher feedback for the mental health classroom observation/supervision cycle; (3) the mental health individual child observation/action plan and, (4) the mental health component evaluations.

Mental Health Classroom Observation/Supervision Cycle

The Los Angeles Head Start Grantee recommends one hour of classroom observation per site followed by one hour of consultation (feedback). Through the Mental Health Classroom Observation/Supervision Cycle, the MHP/IP provided an average of 3½ hours of observation per class followed by a 2 hour feedback with the teaching staff in all 64 classrooms. Thus, 5½ hours of consultation per class provided a total of 352 hours of observation and consultation; considerably more than the Grantee's current recommended hours for observation and consultation (2 hours per site in 23 sites) which would total 46 hours. Furthermore, these 352 hours represent only one aspect of staff training and consultation for the MHP/IP model. Additional hours, as well as strategies for consultation and training of the teaching staff were also provided.

As part of this cycle the mental health counselor evaluated teacher performance and classroom environment. The results of this evaluation demonstrated that 48% of the teaching staff had good or excellent skills; 33% had satisfactory skills, and 19% were either in need of improvement or had unsatisifactory skills. As part of LACA's commitment to providing quality education, the mental health component strove to enhance all the teaching staffs' skills so that a higher percentage of staff would have good or excellent skills.

The highest area of observed difficulty was adult/adult interactions where 40.66% of the teachers showed either a level of needing improvement or unsatisfactory performance. This was demonstrated through observations of teacher and teacher's assistant interactions. At times the relation between the teacher and the assistant teacher appeared strained. A lack of coordination of activities and communication between the teaching staff and parents was observed, and many teaching staff reported not having developed a supportive and trusting rapport with the parents. The counselors observed either a lack of parent volunteers in the classroom or a lack of communication between the teaching staff and the volunteers in their classroom and as a result were unclear of their roles and often ended up doing maintenance tasks. (e.g., cleaning the room, serving food, etc.).

It was evident that teaching staff would benefit from additional training in this area in order to function more effectively in the development of adult/adult interactions by improving communication skills and increasing classroom coordination. Through appropriate interactions between parents, teachers and assistants, an effective role model to the children was provided. In response to parent/teacher interactions, there was a need for initial detailed orientation for the parents on the importance and benefits of their participation in the classroom. A definite need existed for further training of teaching staff on the effective use of parent volunteers in the classroom.

The next highest area of difficulty observed was in relation to the level of positive stimulation provided to the children. 22% of the teaching staff were observed to have had problems in this area which included providing exciting and challenging activities for the children, encouraging the children's initiative and creativity, and displaying enthusiasm for their work. The mental health staff provided an important role in showing the teaching staff how to increase the level of positive stimulation by pointing out the importance of encouraging children's creativity and sense of accomplishment, both of which can greatly increase a child's self-esteem. The authors believed as children play a more active role in the classroom and take age-appropriate responsibility in the classroom their social competence would increase.

Teaching staff were also observed to demonstrate some difficulty in nurturing a child's self-esteem. 47.44% of the teaching staff had good or excellent skills in this area, 32.2% had satisfactory skills, and 20.32% had an unsatisfactory level or needed improvement. Although at first glance it appeared that only 20.32% of the teaching staff had difficulties in this area, it should be noted the 32.2% who were measured as satisfactory, also needed to improve their skills so that nurturing the child's self-esteem would become a priority. Self-esteem is one of the most important elements of social competence and promoting a child's self-esteem should be given significant attention.

Another area of difficulty was behavior management where 49.14% of the teachers were observed to have had good or excellent skills, 30.5% had satisfactory skills, and 20.3% had unsatisfactory skills or needed improvement. Some teaching staff often lacked an understanding of the child's problems and a knowledge of how to deal with specific problem behavior. In some instances, the teaching staff had a clear understanding of the appropriate action to be taken but lacked consistency and follow-through. Although some workshops were given in behavior management, a more intense training effort was needed to provide specific, practical suggestions for coping with problem behavior.

Aside from assessing the level of skills of the teaching staff, the Mental Health Classroom Observation/Supervision Cycle also provided one-on-one training. In all the observed areas mentioned in table 30, according to the specific needs of the teaching staff, needs included behavior management, communication skills, and nurturing children's self-esteem. In addition, the teaching staff were encouraged to discuss with the counselors their own solutions for problems and the teachers were viewed as having expertise in their own particular classroom. Their strengths, not deficits, were built upon.

Another benefit of the consultation process was that teaching staff received specific strategies which were directly applied to their classroom situation. Often, formal academic training to teaching staff consists of theory which is often difficult to translate into practice within a classroom setting. As part of the MHP/IP, the mental health counselor observed the teacher's classroom and responded to the specific strengths and problems that were observed.

The MHP/IP was designed to begin on July 1, 1984, however, the U.S. Department of Health and Human Services altered that starting date to

September 1, 1984, because of delays in processing procedures. Actually, funds were not received until the end of October. As a result, this delay affected planning, implementation and coordination of services among mental health and the other components. Although the cycles were to have been completed in the first three months of the program year 1984-1985, some of them were done later in the year. More than 90% were completed by December 14, 1984 and the rest were completed by January 31, 1985. One of the implications of this lack of coordination among mental health and the other components was that priority was not given for the joint scheduling of the cycles. To remedy this situation, the mental health counselor met with the Child Development Specialist (CDS) after the cycle to review the observation and discussed suggestions for improving the classroom environment.

The cycle promoted early identification and intervention of children with problems. In comparing LACA to other Head Start agencies it was found the mean number of referrals from September 1 - December 31, 1984 was 8 referrals per agency representing 2.3% of the Los Angeles County Head Start population. LACA had 111 (12%) referrals for the same time period. One reason for the low ratio of County referrals was due to a lack of priority and understanding of mental health and consequently, the children who were in need of mental health services were not being referred. This is confirmed in the literature which indicates 10% - 25% of children in Head Start classrooms are thought to suffer from serious psychological and developmental disturbances.

The significant difference in this project is due to the MHP/IP providing for early identification by conducting comprehensive classroom observations and training of the teaching staff on how to identify behavior and emotional problems which interfered with a child's normal growth and development, and to refer these children to appropriate components.

Teacher Feedback of the Mental Health Classroom Observation/Supervision Cycle

Following the Mental Health Classroom Observation/Supervision Cycle, the teaching staff filled out the Teacher Feedback form on which they gave their comments on the cycle. As stated previously, 89% found the cycle to be helpful, while 11% found it not to be helpful.

In contrast to the teaching supervisors' first impressions, which assumed the teaching staff did not want training due to their already existing work load, teacher's responses demonstrated a vast majority were in favor of receiving training and valued the mental health staff's assistance in helping them in effectively carrying out their roles as teachers in the classroom. In this study, we have observed that hands-on-training is an effective means of improving teaching skills. When training is presented from a positive standpoint, builds upon existing strengths, not deficits, acknowledges teacher skills and expertise, and actually demonstrates how these skills are essential in promoting an emotionally supportive environment in the classroom, then the teaching staff should be responsive to this form of intervention.

Nevertheless, a problem faced by the mental health component was the resistance demonstrated by 11% of the teaching staff to having an outsider come into the classroom, observe the class, and point out problems. An effort was made to be sensitive to the teachers' feelings and not to emphasize deficits, but rather to build on the teachers' existing strengths. Despite these intentions, these teacher's were resistant to ideas given by the mental health staff. These problems were handled as they arose, and mental health requested the presence of the CDS in resolving conflicting situations.

The MHP/IP supported teaching staff as critical to the emotional and physical well-being of the child in the classroom. 58% of the teaching staff completed the teacher feedback form of the Mental Health Classroom Observation/Supervision Cycle. When the forms were given to the teachers, it was explained they could give feedback on the strengths as well as the weaknesses of the cycle. The counselors explained to the teachers that their responses to the cycle were highly valued and would be used to improve the effectiveness of the staff training and consultation aspect of the MHP/IP. An open atmosphere to feedback was fostered. The form used for the teacher feedback also requested a narrative response. It is recommended that in the future a more detailed form be used that asks more specific questions and would lend itself to a more detailed analysis.

Mental Health Individual Child Observation/Action Plan

After a referral was received, a mental health counselor conducted a classroom observation of the child and worked with the teaching staff to develop an appropriate course of action for resolving the problems. By working with the mental health counselor, the teacher had the opportunity to increase skills and develop his or her sense of competence as a teacher. Early identification and intervention took place with the potential to reduce existing problems that could have long-range damaging effects (e.g., child referred to mental health component for excessive aggressive behavior).

One of the most important aspects of this intervention was the provision of direct training to the teaching staff in handling the specific emotional and behavioral problems of a referred child. Possible causes and effects of manifested behaviors were explained and strategies for resolving these problems were given. As the teaching staff acquired an understanding of the problem and developed skills to effectively assist the child with the manifesting problem behavior, their level of classroom performance and self-esteem were reported to have improved.

The Mental Health Individual Child Observation/Action Plan was followed by a parent/teacher conference. At this time the parent, the teaching staff and the mental health counselor jointly discussed the problem and recommendations for intervention, thus emphasizing a team approach in treating the problem.

In addition, the teaching staff acquired knowledge on the differences between the cause and the effect of behaviors and were able to recognize the need for treating the cause and not just the symptom, which in most cases was the behavior manifested in the classroom. As a result, the teaching staff was able to understand and support the approach of working with the entire family, not just the child in isolation.

In the majority of cases, the family received counseling, and therefore, it was essential for the counselor to make the parent and teacher aware of the need for consistency between interventions at home and at school. The more involved the teachers felt in the team approach, the more effective they appeared in providing an emotionally supportive environment in the classroom. When the mental health counselor conducted the individual child observation, it also gave them the opportunity to observe other children and make other referrals as needed.

Although the Action Plan provided an effective intervention, in some instances the teaching staff did not follow-through on the training which was given to them. In this situation it was necessary for the counselor to have an additional consultation with the teacher to clarify the Action Plan and to discuss possible barriers to its implementation.

There were also some difficulties in providing services to the teaching staff. In a few situations, for example, the teaching staff grew dependent on the counselor and did not develop their own skills. Others did not initiate any contact with the mental health staff; rather, they waited to be contacted by the counselor even when there was a serious need for assistance.

At times, when the teaching staff did not follow-through on the recommended Action Plan and/or the case was serious enough that it required training, the MHP/IP provided this additional training and consultation which took the form of classroom observations, meetings between the counselor, teaching staff, and/or parents, and telephone consultations. Through these repeated contacts, the teaching staff developed trust in the counselor and mental health services. Still, there were teachers who had low levels of skills who would have required extensive long term training in order to perform at a satisfactory level. The MHP/IP was not designed to solely provide extensive long-term training to teaching staff who did not have basic skills. It has been the authors' observation that when one provides direct training to teachers, acknowledging their strengths, their motivational level and trust in themselves as teachers will increase.

Staff Evaluation of Mental Health Services

In February, 1985, the mental health component was evaluated by the teaching staff. This evaluation consisted of narrative responses and covered the following areas: (1) helpful services; (2) services most valued;

(3) inappropriate services; and (4) lacking or insufficient services. The results for the mental health component covered the areas of service delivery to teachers, parents and children. The purpose of these evaluations was to expose weaknesses and strengths in the components so appropriate changes could be made to provide optimal services to our children and families. These evaluations underscored the teachers' importance in the Head Start program and demonstrated their recommendations were critical in the improvement of mental health service delivery.

The overall results reflected the teaching staff's feelings that service delivery for children and families was effective. They stated that on site direct training provided insight and strategies on how to minimize the incidences of behavioral problems, it facilitated their interaction with parents and gave them an understanding of the importance of identifying and treating children and families mental health needs. These evaluations were also significant because teacher evaluations provided the mental health component with direct input on the effectiveness of service delivery. The teaching staff's recommendations for improvement were significant and due to the anonymity of the evaluation form, it is thought teachers truly expressed their perceptions as well as their experience with the mental health component.

Recommendations for Staff Training and Consultation

The Synthesis Project (McKey, 1985) states there have been no evaluation studies measuring the effectiveness of staff training and consultation which led the authors' to believe that the potential of staff training and consultation has not yet been explored by Head Start.

One recommendation for a successful training and consultation aspect of a Head Start program is the initial orientation (or possibly re-orientation) of the staff to the primary goal of Head Start - the promotion of social competence with the children and families served by the program. The authors believe that when staff understand the goal of the program, they can ideally unite as a team and together provide comprehensive multi-disciplinary services to promote child and family development in the fullest sense as well as to understand the importance of mental health service delivery. When the stigmas attached to mental health are directly presented to the staff, the process of shifting the existing negative focus of mental health to a positive understanding of the need for mental health services begins. When this is followed by giving the staff a direct, positive experience of mental health service delivery, then their receptivity will be instrumental in the coordination and implementation of the comprehensive services provided.

In addition to providing comprehensive mental health services to the children with more serious problems, there is a need to have skilled teaching staff who are able to assist mental health counselors with classroom interventions. The teaching staff need to have an understanding of the importance of an emotionally supportive environment. When these skills are not present, the result is most likely to be an increase in the severity of the problem because of a lack of early identification. This may mean that instead of giving the child a "head start", a program may be perpetuating a problem which could lead to long term pathology (e.g., a child with severe withdrawn behavior).

In discussing staffing and consultation in the mental health classroom observation/supervision cycle, it was discovered teaching staff highly regard training in assisting them in effectively carrying out their roles as teachers. Furthermore, when training focuses on showing teachers how effective mental health skills are in promoting an emotionally supportive environment in the classroom, their response to training is even greater. The success of direct hands-on-training is based on a model of comprehensive observation and feedback addressing specific situations and problems arising in the classroom, rather than just providing theoretical training.

Since classroom observations were conducted on referrals received by the mental health component and direct training was provided to the teaching staff, mental health counselors had an opportunity to observe, and conclude the importance and need for, individualized training of teachers in handling the specific emotional and behavioral problems of a referred child. Possible causes and effects of manifested behaviors were clearly explained so that the origin of the problem and the prescribed course of treatment in the classroom were understood. For example, Robert T. who was diagnosed as childhood onset developmental disorder did not at first have a nurturing supportive classroom environment. The teaching team did not understand the cause of Robert's behavior and did not know how to handle his daily aggressive behavior which completely disrupted the entire classroom environment. At times the child was withdrawn, had limited and unclear speech, and showed difficulty in understanding directions. He was experiencing sudden excessive anxiety manifested by catastrophic reactions to everyday occurrences, an inability to be consoled when upset, unexplained rage reactions, an inability to maintain meaningful contact with adults and peers, resistence to change in the environment, speech delays and nightly head banging. He was referred to County Regional Center for evaluation, but his delays were not specific enough to that agency's requirements to accept him as a client. Through staff training and consultation, the mental health counselor explained in depth to the teaching staff that Robert's severe delays were a result of the neglect and abuse he had received in the first three years of his life. Through staff training, the teaching staff understood the need to provide a loving, supportive and stable environment. Since Robert was receiving negative reinforcement for his acting out behavior, the teachers were trained to withdraw their constant attention from him and nurture his interactions with other children. The teaching staff was trained not to single Robert out but to engage him as they would with any other child in helping activities as well as all other activities in order to foster his independence and self-esteem. The teachers assured him of their continuous presence and continuity of environment (e.g., food, nurture object consistency, etc.). They were trained on giving clear messages to Robert and maintaining consistent follow through. The mental health counselor also coordinated service delivery between the teaching staff and the foster mother so consistency between classroom environment and home environment existed.

This example reflects, in an individual case, the need for comprehensive classroom direct training. It was observed the majority of teaching staff were unaware of the severity and impact of high risk factors and how these problems could be minimized in the classroom, therefore facilitating the success of treatment in handling the severe problems they are faced with daily. In other words, it is believed that when teaching staffs' actual classroom situations and problems are used for training, rather than just a theoretical approach, the potential for success and immediate gain by the teaching staff is greater.

The review of the consultation literature concurs with our findings which show there is a higher rate of success in response to training when there is a high level of interaction with the trainer. The authors believe one way to foster a higher level of interaction between the teaching staff and trainer is to actively involve the teaching staff in the process of determining the areas that need training. Once the teaching staff and the trainer jointly agree on a plan for training and participation, success is more likely to be accomplished. If the teaching staff had continued to be unable to handle Robert's daily disruptive behavior in the class, this would have had a major effect on reinforcing his existing severe pathology. In addition, if individual mental health intervention had not been provided, the severe daily disruption of the class would have had a major effect on the other 15 children in the class. Thus, extensive comprehensive staff training and consultation is necessary if we are to truly assist the children and families we serve.

As previously discussed, LACA's mental health program strongly emphasized the idea of a team approach among the components of Head Start and the mental health component. The coordination of services among the components was an essential aspect of the program in providing comprehensive successful direct mental health services. In addition to an all out effort by the mental health staff to involve all the components in the delivery of services, a team approach to treatment involving the parent, the teaching staff, and the counselor was considered to be of primary importance for effective service delivery. Such an approach proved to be effective in treating child behavior, emotional problems and overall family dysfunction. As parents participated in the process of treatment they were trained in how to effectively promote a well structured, nurturing and consistent environment for their children and the coordination of training for teaching staff in order to promote a high level of consistency between home environment and classroom environment.

Referring back to Robert's case, for instance, the participation and involvement of his foster mother in the treatment was essential to his need for a well structured and consistent environment. In most cases, the parent(s) and teaching staff needed to agree and understand the importance of providing a child with consistency in whatever intervention was being received at home and school.

It is recommended that mental health in Head Start provide for this level of coordination, among the components; a team approach consisting of parent(s), the teaching staff and the counselor, which can then result in consistency between home and school environment. Mental health in Head Start needs to support parents as the primary educators of their children and value their input and strengths in the outcome of any intervention process with children. Furthermore, this coordination and team approach will tend to minimize possible dependence of the teaching staff and parents on the mental health staff for solving "problems" in the classroom. As discussed earlier, perhaps due to a lack of self-esteem and overall insecurities of teachers and parents in effectively nurturing and disciplining their children, some teachers and parents may have grown dependent on the mental health staff and perceived them as their saviors who would rescue them from the classroom and/or home environment problems they were unable to solve. However, with the team approach emphasizing how essential both the teaching staff and the parents' strengths are for the emotional, healthy development of the child, the problem of dependency can be minimized. Nevertheless, mental health staff working with parents and teaching staff need to consider, in spite of the approach, that some parents and teachers may need therapeutic work in order to assist with unresolved dependency issues.

The MHP/IP focused on the relationship between the cause and effect of behavior. This aspect of the program proved to be effective since it did not focus on treating symptoms alone. In Head Start, as well as in the overall educational system, parents, teaching staff and even professionals have tended to focus on treating the child in isolation from the parents/family. Even though the literature has indicated a need to shift social service programs from a child centered to a family-centered program (HHS, 1980), the idea still remains quite unexplored. The MHP/IP recommends the family be treated as an entire unit. The child is a part of that unit and can not be treated in isolation from the family. The symptoms of the problem can no longer be treated alone. The entire family must be treated if any effective, permanent change is to occur.

As indicated in chapter two, Head Start provides mental health services primarily through the use of consultants. There has been a whole range of quality services provided by consultants, but for the most part, these services have not met the needs of this high risk population. Since these consultants rarely have an understanding of the interdependence between components which provide for built-in accountability for service delivery, comprehensive mental health services in Head Start have been ineffective and virtually nonexistant. Parents and the teaching staff will rarely disclose information to a para-professional or professional who cannot provide a plan for resolution of the problem, but instead offers addresses and phone numbers of agencies where these people should seek help.

The authors recommend that full time Head Start mental health staff be the providers of services rather than outside consultants. This plan could be replicated and adapted based upon the different needs across the nation. Direct mental health services in Head Start need to receive priority for funding as indicated by experts in the field who have, for the past 20 years, underlined the dire need for mental health prevention and intervention.

It is imperative the National Head Start Bureau recognize the importance of staff training and consultation in the area of mental health. Since Head Start serves a high risk population faced with severe problems, there is a critical need of having qualified, trained staff in the classroom who can understand, support and promote child and family development in the fullest sense, allowing for the accomplishment of the primary goal of Head Start - the promotion of social competence.

CHAPTER 12

PARENT EDUCATION AND INVOLVEMENT

Overview

The MHP/IP Project sought to increase parental involvement through a series of activities emphasizing parent education sessions, family nights, intensive parent education/staff training and parent support groups. Overall, it was felt these activities would further develop the social competence of parents, and thus remain in keeping with the objectives of the study.

There were problems in realizing these goals for a myriad of reasons. The lack of successful outcomes were rooted in both internal and external workings related to the MHP/IP Project. As mentioned in Chapter 9, a comprehensive low cost parent education program was designed for the MHP/IP. Though the MHP/IP, under the mental health component made this initial plan for parent education with the approval of LACA's administration, when it came down to carrying out the actual program the parent involvement component, with the support of the administration, designed and implemented their own plan for parent education which tended to revert back to the old model of focusing more on involvement than education and involvement. This problem seemed to be rooted in an overall lack of clarity regarding what parent involvement, parent education, and parent participation actually means on a policy level for this and most Head Start programs.

Internal Factors

The focus of the MHP/IP was the testing of three intervention strategies - staff training and consultation, parent education and involvement, and in-house mental health service delivery leading to early identification and intervention. In parent education and involvement there were activities organized for parents which would enable them to learn more about the parenting process, become more involved in Head Start activities and at the same time, improve their social competence as the primary educators of their children.

After the project was implemented and activities organized, parent participation, at least at family nights, was relatively low because of a lack of coordination among parent involvement and other components. In addition, a problem which hampered the success of this activity was the fact management did not hire the parent educators until the end of January, 1985. Logistically, this became another serious oversight. On the one hand, the parent education sessions were originally scheduled to take place between October and November of 1984. In this way, those parents who wanted more training could be scheduled for additional sessions during February and March of 1985. From here, parent support groups would be organized at local sites where parents would then provide leadership and support to parents who needed more help. As it turned out, with the parent educators not beginning their sessions until March, and these were scheduled through May, it became obvious that there would not be time for the intensive parent education sessions, nor for the development of parents' support groups since the year would come to a close during the second week of June.

The decisions surrounding parent involvement by LACA's administration reflects the dilemma of priority for parent education. Not hiring parent educators at the beginning of the school year no doubt affected the quality of follow through with families interested in participating in education and support groups. Traditionally, parent education has not been given a priority in Head Start. And when parent education has been provided, it has been for the purpose of disseminating information and not for the purpose of education and community development. The development of parent support groups who become involved at the policy level with the education of their own children, is an ideal goal to achieve. The parent education component of LACA and most other Head Start programs must reevaluate the original goals of parent education and involvement to encourage a more active and viable role for Head Start parents.

External Factors

There is no argument with the fact that parent involvement is an important aspect of a child's education (Bronfenbrenner, et. al., 1983; Totter and Robinson, 1982). Nevertheless, the literature on parents participating in Head Start shows no clear impact (McKey, 1985). While on the one hand, there are some studies (Adams, 1976) which show parents involved with Head Start as employees or as members of policymaking committees gain self-confidence, control over their lives, and a marked increase in community participation, there have been no systematic studies which confirm or disconfirm this fact on a national basis.

A factor which affected the MHP/IP was the different levels of parent involvement and the degree to which these levels were realized. For the most part, Head Start policy requires that parents be involved in 1) Participation in the process of making policy about the nature and operation of the program, 2) Participation in the classroom as paid employees, volunteers or as observers, 3) Development of a plan for parent programs which are responsive to the needs expressed by the parents themselves - For example, should parents express a desire to organize around housing issues, a plan must be developed that would allow for such involvement - and 4) home visits, where permitted by parents, should include activities developed by staff for implementation with the family (Head Start Policy Manual, 1970).

This brings one to the contradiction of what is meant by parent involvement, parent education, and parent participation. These definitions have meant different things to different people. Attempts to curtail parent involvement in political organizing led to a redirection of Head Start policy to a more workable, and safer, combination of participation in decision making (e.g. hiring of staff) and parent education, was seen as providing parenting skills to parents however, this has various degrees of implementation. More importantly, participation signified a step towards their self-determination (Valentine and Stark, 1979:295). It is this latter role which has not received attention in the literature.

From observations of the parent involvement component at LACA's Head Start program, staff members seem to have differing views of how to work with parents. On the one hand, some staff believe, the role of the parent involvement component is to empower parents to take control of their own lives. This is an act which would definitely, help them to improve their social competence. On the other, some individuals believe parents have to be told what to do; or that parents do not want to be leaders but would rather do arts and crafts. This discrepancy is reflective of what occurs in Head Start nationally.

Recommendations for Parent Education and Involvement

The MHP/IP sought to increase parental involvement through a series of activities which would emphasize parenting skills, child development, and the formation of parent support groups at a site level. Overall, it was felt these activities would further develop the social competence of parents, and thus remain in keeping with the overall objectives of the study. Along the way, plans for carrying out activities with parents seemed to have lost importance, so much so, that parent education and involvement resembled a mere supplemental activity. On another level, this problem seemed to be rooted to the overall lack of clarity regarding what parent involvement, parent education, and parent participation actually mean on a policy level.

The authors, therefore, recommend the National Head Start Bureau shift the current focus from parent involvement to parent education and involvement. Within the Parent Involvement Performance Standards there is an existing focus on education; a theoretical focus which has not been widely integrated in individual Head Start programs. It is recommended the Head Start Bureau select effective parent education models which can be implemented at the local level based on individual needs and/or cultural relevance. These models should emphasize the role of parents as the primary educators of their children and can be carried out by promoting parents as partners with program staff in accomplishing the goal of Head Start. These models should also help prepare parents to be trainers of other parents and thus serve as role models in the program.

Finally, these models should promote the social competence of parents by enhancing their sense of self-esteem and thus creating leadership abilities which can, in turn, enhance their role as individuals, as parents, and as members of society.

Chapter 13

IN-HOUSE MENTAL HEALTH TREATMENT SERVICES

Overview

One of the main reasons which led the authors to design and implement the MHP/IP was the clear evidence in Head Start of the need for comprehensive mental health service delivery. This need was verified not only through the authors' experience in the field of mental health and Head Start, but also through the literature. "Although Head Start programs are required to include a mental health component, no studies were located that evaluate the effect of mental health services (McKey, 1985:16)." Furthermore, the literature has consistently shown that 10% to 25% of Head Start children are in dire need of mental health services (Cohen et. al., 1979).

The national Head Start program could be said to have placed its greatest emphasis on the preschool child's achievement of lasting intellectual skills through early cognitive oriented education. In comparison, there has been little explicit attention given to the child's emotional development and psychological difficulties. Head Start has undergone a variety of changes over the years, but of all the components, what was originally known as psychological services and is now known as mental health, has been the least visible, least adequately funded and least valued (Cohen, et. al., 1979). To date, no model for mental health service delivery has been developed, let alone, evaluated, to be an effective means of providing mental health services to Head Start children and families. This section includes a discussion regarding the findings as well as a presentation of recommendations for in-house mental health treatment services.

Discussion

The MHP/IP proposed a shift from a child-centered to a family-centered program; a shift also proposed in a HHS 1980 report. The authors believe the child should not be seen in isolation. The child should be viewed as an integral part of the family structure whereby problems that affect the functioning of the family also affect the functioning of the child.

For example, the initial assessments made on the child addressed problems evident in the classroom. However, when the mental health counselors reassessed the child and the original presenting problem, it was discovered that in most cases, parent/family problems were the actual cause of the behaviors manifested by the child in the classroom. This shift from a child-centered approach to a family-centered approach was based on the ecological approach employed by the MHP/IP which emphasized the interconnectiveness of systems impacting on the family. The assumption was borne out by the findings where the original presenting problem, in 75% of the cases, reflected child problems and 25% of the cases were parent/family problems. After assessment, however, in 16% of the cases, the problem remained child-centered but 84% of the cases reflected parent/family problems.

It was through this assessment that the mental health counseling staff came to realize problems of aggressive behavior in Head Start children, for example, were actually caused by parent/family problems such as, lack of parenting skills, separation and marital problems, etc. Basically, the cause of a problem was due to disruptive and/or dysfunctional family dynamics, not the child alone. It became obvious to the authors that treatment of the original presenting problems alone would have caused the child to become the identified patient, and the origin of the problem would have gone unresolved.

The use of an ecological model for treatment by the MHP/IP sought to bridge the gap between mental health treatment services and the interconnectiveness of systems that affected the family. The MHP/IP viewed the child and family from a holistic systems orientation - a multivectored ecological model of treatment was used combining biological, psychological, social and environmental factors.

Human service delivery programs portray one example of this conflict. Historically these programs have viewed the individual in isolation from large, external issues which may impact on their lives. The attitudes emanating from human service bureaucracies have largely "blamed the victim" for problems which affect the family. The net effect of such views have merely generated the distrust and suspicion of the client towards human service delivery programs.

The ecological model addresses the origin of the problem and the configuration between the systems affecting the family and places great emphasis on individual and family responsibility as a viable alternative to the position of blaming the victim. By addressing the causes of a problem, the ecological holistic perspective allows for the improvement of the individual, promoting their social competence, and enabling them to better adjust and cope with their lives.

Most importantly, through the ecological model, the MHP/IP designed a demonstration model to promote social competence in children and families. Inherent in this model was a shift from deficit models that placed responsibility for problems on families alone, to a program structure emphasizing the existing strengths inherent within the child and family. The MHP/IP staff sought to build on a family's existing strengths regardless of language skills, economic or educational status. The counseling staff, by viewing parental relationships as the most critical in a child's life, acknowledged and gave the utmost respect to parents in their role as the primary educators of their children.

Recommendations for In-House Mental Health Treatment Services

National Head Start Bureau

A primary recommendation of the MHP/IP is that the Head Start Bureau recognize the importance of mental health as a critical component in accomplishing the primary goal of Head Start - the promotion of social competence. This can be accomplished by recognizing the importance and need for comprehensive mental health services for Head Start populations as well as establishing mental health as a priority in the areas of funding and training. The National Head Start Bureau has already begun to recognize the importance of mental health by targeting funds for mental health under the discretionary grants and by initiating a national Mental Health Task Force in May, 1985. However, discretionary grants and a Task Force alone are not sufficient to impact on mental health in Head Start, unless there is a serious committment and an all-out united effort to insure a national change in mental health in Head Start.

Is Head Start not acknowledging the severe emotional and developmental problems of the children and families it serves because administrators do not view mental health as a priority and do not consider it their responsibility to handle these problems? Is it believed that Head Start should refer children and families with psychological and developmental problems to outside community agencies, even though research has shown that this population will rarely use these services? Or is it that Head Start administrators genuinely do not know what to do to resolve these problems and/or they believe that the problems these children and families are faced with are so severe that they cannot possibly be resolved? The MHP/IP recommends a national mental health needs assessment be conducted in Head Start for the purpose of gathering substantial data which can be used to assess the needs of Head Start children and families, and the levels of mental health services that are presently being delivered. Such an assessment can be useful in formulating a national plan for upgrading Head Start services as well as impacting on the formulation and implementation of Head Start policy.

The Head Start Bureau can also make mental health a training priority under Training and Technical Assistance (T & TA). This training should address the following points:

1) The need to shift from the existing cognitive orientation in Head Start to the original goal of social competence;

2) The importance of mental health in the accomplishment of this goal;

3) A committment to the shift from a child-centered program to a family-centered program;

4) A greater emphasis on parents as the primary educators of their children;

5) Address the stigma attached to mental health and develop ways to counteract it;

6) Recognize the relevance of switching the focus in mental health from pathology, to health and wellness;

7) The importance of prevention, early identification and intervention of child and family related dysfunctions which have the potential of producing long-range damaging effects;

8) The multi-disciplinary team approach to the delivery of services to Head Start families; and

9) The development of working models for implementing mental health service delivery in various settings (i.e., urban, rural, etc.).

Since this Training and Technical Assistance needs to be an all-out national effort in order to become successful, the authors are recommending that training be provided to the following people: 1) Head Start Bureau Administrative Staff; 2) Head Start Regional Administrative staff; 3) Grantee Administrative staff; 4) Head Start directors and component supervisors staff; and 5) Head Start teaching and component support staff. The National Head Start Bureau has begun to recognize the need for mental health but, recognition is not sufficient without the full support of substantial funding.

Comprehensive Mental Health Services Need to be Provided by Head Start

The authors are recommending Head Start agencies implement comprehensive, in-house, direct mental health service delivery programs which provide for prevention, early identification and intervention of problems for children and families. The MHP/IP offers a model that can be replicated and adapted in various urban and rural settings to meet the individual needs of Head Start agencies across the nation. It is recommended that Head Start's urban programs hire a full time, licensed mental health professional, whose sole responsibility is the supervision of the mental health component, rather than contract with outside consultants.

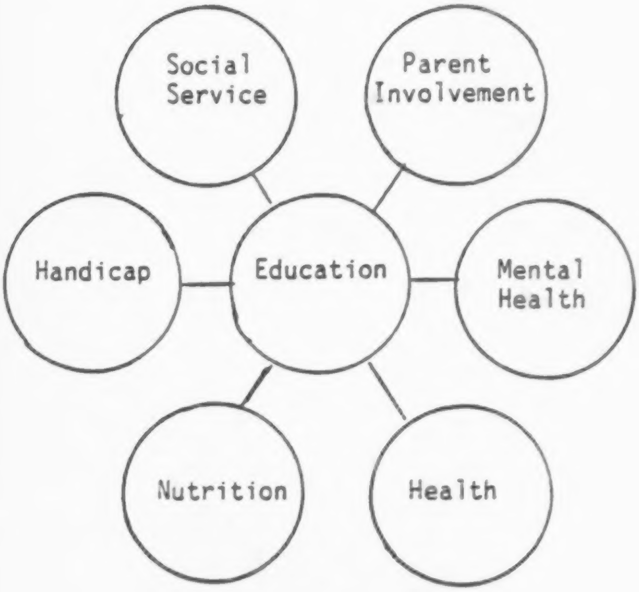
Head Start can also set up internship programs with volunteer or stipend graduate interns in the fields of psychology, counseling, early childhood education, social work, and other related fields. Under the supervision of the licensed Mental Health Specialist, all mental health staff, including interns, will undergo comprehensive training to provide in-house, direct mental health services to the children, families, and teachers. Counselors should have a background in early childhood development, counseling, an interest in working with a high risk population and when needed, bilingual capabilities. Counselors should be culturally sensitive to ethnic populations that are being served. Head Start can then become an established, recognized, ecologically oriented training ground for future therapists and child development experts specializing in the fields of children, families, high risk populations, cross-cultural counseling, prevention, health and wellness. This ecologically oriented program has far reaching implications in the area of psychology, switching the existing focus from pathology and a deficit model, to a focus on prevention, health, wellness, social competence, and family strengths.

In rural settings, different Head Start centers could pool their resources for mental health services, and jointly hire a licensed mental health specialist who would then provide a plan for recruitment, training and supervision of staff. Para-professionals and stipend graduate interns would be the providers of services to these rural centers. The great distance between many rural Head Start centers would also have to be taken into consideration in working out a plan of accessible services onsite or in the home.

If certain Head Start agencies are unable to develop a plan to provide in-house direct mental health services, then these agencies should establish formal linkages with existing mental health community agencies which would provide for the early identification and intervention in problems affecting the Head Start child and family. The mental health community agencies should have staff who are able to handle the problems associated with high risk. The authors' experience has been that mental health agencies generally do not provide for prevention and early identification of problems in children and families due to large case loads, long waiting lists, and low priority in funding for services for children, families, minorities and non-English speaking populations. Therefore, if these linkages are to occur, the provision of comprehensive mental health services to the Head Start population should be incorporated in the overall planning of services of existing mental health agencies. It is further recommended that under the Mental Health Block Grants to states, Head Start be incorporated into the regular budget for funding of mental health services. Head Start presently serves approximately 400,000 children a year. Each family has an average of 5 people per household. Head Start has the potential to provide services to approximately 2 million people annually. A model such as the MHP/IP, which provides comprehensive mental health services in the areas of prevention, early identification and intervention, has the potential, over a generation, to enhance the lives of 40 million people. At present, there is no other model that has the potential to strengthen the lives of children and families in this country in this way.

Shifting the Focus in Head Start from Promoting Cognitive Development to Promoting Social Competence

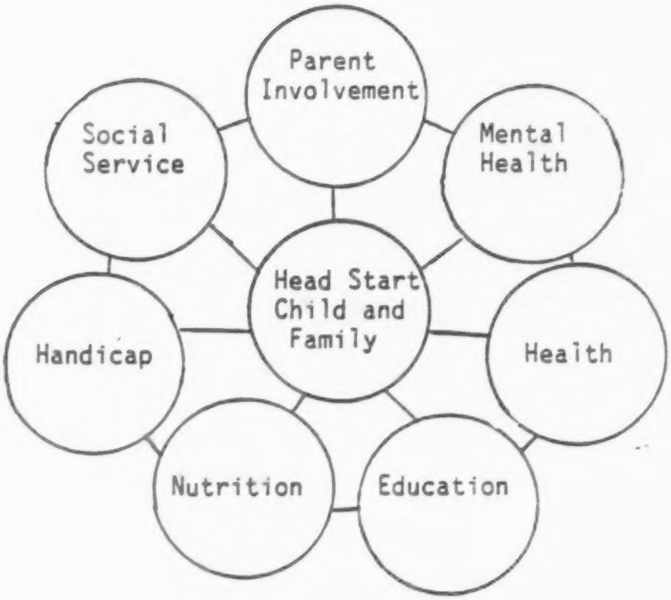
As previously stated, to date Head Start has had its primary focus on cognitive oriented education with an emphasis on the components serving the education component. The MHP/IP proposes a model where all the components work cooperatively and interdependently to serve the Head Start child and family. In this regard, the MHP/IP is proposing a shift from a program which has primarily emphasized cognitive development, where all the components serve the education component, to a program which focuses on the promotion of social competence. All the components, including the education component, would serve the Head Start child and family.


Social Service
Parent Involvement
Handicap
Education
Mental Health
Nutrition
Health

EXISTING MODEL

Focusing on the cognitive development of the child

Child Centered Program


Parent Involvement
Social Service
Mental Health
Head Start Child and Family
Handicap
Health
Nutrition
Education

PROPOSED MODEL

Focusing on the promotion of social competence in the child and family

Family Centered Program

In the existing model all Head Start components serve the education component which primarily focuses on the cognitive development of the child (child-centered program). The MHP/IP recommends a shift to the proposed model which has all the components of Head Start, including the education component, functioning interdependently within the framework of a multidisciplinary team approach aimed at accomplishing Head Start's ultimate goal: the promotion of social competence in children and families (family-centered program).

An Ecological Model for Mental Health Service Delivery

The MHP/IP is recommending the use of an ecological model with its broader focus over the less effective deficit models. The child is not a cognitive entity alone: He or she must be viewed from an ecological perspective. The child has a physical body and a social and emotional essence and must be viewed as an integral being who interdependently relates to his family, community and society. The authors' are recommending the Head Start child and family be viewed from a holistics systems orientation to treatment, where the child and the family are seen as interacting within a number of systems - biological, psychological, social and environmental. The MHP/IP suggests that for educational and human service delivery on a national level, the Head Start child no longer be viewed in isolation from the family. A problem that affects one family member affects the whole family.

The ecological model addresses the origin of the problem and the interconnectiveness between the systems affecting the family. Therefore, when a child is exhibiting problem behavior in the classroom, (e.g., aggression, withdrawal, etc.) the origin or cause of the problem (e.g., family conflict) is treated. Many practitioners in Head Start have tended to focus on the effect of the problem rather than the cause, and thus perpetuating the belief that the child and family are the "victims of society". For instance, when a child's basic needs are not being met, i.e., food and shelter, what Head Start has tended to do is to give the child a "head start" in the classroom and help to resolve the basic need for food and shelter, instead of looking at the causes which have led the family to be dysfunctional. Poverty, discrimination, unemployment and other social ills of the times seriously impact on the healthy functioning of a family, however, the fact that some families are faced with these problems and are still able to successfully function, leads one to believe that factors other than environmental and social ones also contribute to the family functioning. The potential to overcome social ills begins when one becomes aware of the interconnectiveness between the internal (persona) and external (societal) factors. The MHP/IP is based on the ecological model which address the whole person both the internal and external factors affecting this high risk group.

The MHP/IP promotes individual and family responsibility, and proposes alternatives for problem resolution instead of blaming the victim and/or blaming society. In order to impact on the total family system, an emphasis should be placed on treating the entire family, not just the child in isolation, who has become the identified problem. The child's behavior is seen as one of the effects of a family's dynamics. Human service delivery systems need to treat the cause of a problem, if the goal is to make long term significant changes in children and families. The families in this study were assisted to look at both internal and external issues not in terms of deficits, but rather as areas that could be changed if the individual so desired. The MHP/IP is recommending the ecological approach become the state of the art in programs aimed at strengthening families abilities to learn effective new means to improve their lives and successfully function in society.

A Team Approach to Mental Health Service Delivery

A mental health service delivery plan needs to emphasize a team approach where the parent, teacher, and mental health counselor work together in promoting child and family development in the fullest sense. When there is coordination between parents, teachers, and counselors, a consistency will result between the home and school environment. Teachers need to be trained to recognize how critical the parents role is and how to effectively interact with parents. Parents must also be viewed as the primary educators of their children.

Impacting Change in Human Services and the Educational System

The MHP/IP can serve as a model to affect change in human services and the educational system. It proposes that programs in human services move away from an orientation on the deficit model, to a focus on a competency model building on the child and/or family's inherent strengths. Programs need to move their concentration from pathology and treatment to a focus on prevention, health and wellness. For human services and the educational system the child can no longer be viewed in isolation from his or her family. Families need to be treated as an integral unit.

Much of the work done through the MHP/IP involved primary and secondary prevention. This preventive focus contrasts with the typical tertiary, remediation interventions that traditional mental health programs focus on. Many of the problems seen at LACA were at early stages of development. Early intervention had the potential to resolve these problems. As an example, in many cases, the potential for child abuse was present. However, because of the early intervention which focused on parenting skills, reducing stress and improving family communication, these potential problems were diverted. If some of the money for the treatment of child abuse were redirected to the prevention of this problem through such programs as the MHP/IP, it is assumed there would be a substantial reduction in child abuse.

For the educational system it is recommended all children be observed during the first two years of school by a mental health specialist so prevention and early identification of psychological and developmental disturbances might occur. If a problem were observed, a conference could be scheduled with the parent, teacher and mental health specialist. At this time a plan for intervention would be recommended. Either the child and family could be seen by the school psychologist, graduate psychology/counseling intern or a referral to an outside agency could be made. During the first two years of school, all parents would be provided the opportunity to attend parent education classes. The focus would be on parents as the primary educators of their children and increasing their understanding and skills in their critical parental role.

For these changes to occur in the educational system, the public must first become aware of the importance of social competence and its impact on a child's educational performance, his or her functioning within the family system, and in society at large. This awareness needs to be followed by legislative action and budget allocations. Mental health programs in the educational system and programs such as the MHP/IP, in conjunction with longitudinal studies, could be an important step in reducing high risk which can result in mental illness, juvenile delinquency, school drop-outs, incarcerations, alcohol and drug abuse. These programs have the potential of strengthening the children and families of this country. The education system needs to switch its current focus from the cognitive approach to an ecological approach, seeing the child as a whole person by emphasizing his or her interaction with the family and society. The ecological orientation promotes social competence which nurtures an individual's sense of self-esteem, individual responsibility, personal integrity, interdependence, one's effectiveness in dealing with his or her environment, and a concern for the whole.

Chapter 14

SOCIAL COMPETENCE AND THE ECOLOGICAL APPROACH TO THE CHILD

Overview

In recent years the movement towards a clearer and more relevant meaning of social competence has been suggested (Zigler and Farber, 1984). In relation to children, the measurement of social competence must also include an ecological approach of understanding the child within the context of the family from which he/she develops. In addition, children of the age where education is believed to be necessary for the development of social competence must be assessed in the settings which are structured to provide this learning. In Headstart, for example, the mandate to provide educational opportunity to low income children and their families requires that social competence be assessed in the context of this opportunity.

For purposes of social intervention, factors of social competence are recognized for their impact on emotional or social developmental growth. Social competence, for example, has been defined as a combination of four factors described as: 1) cognitive ability, 2) social adjustment, 3) physical health, and 4) self concept. It has been suggested that someone lacking in these characteristics would not be socially competent and in fact, likely to suffer from other disabilities including mental illness (Zigler and Farber, 1984). This view of competence by definition, implies a perception of functional capability on the part of the individual, both in the assessment and evaluation of competence. A child's level of competence and the context in which this competence is demonstrated must be recognized within the social context in which it is being observed. The view, for example, that a child is observed with behavioral problems in the classroom and subsequently identified as "acting out" behaviors of larger family concerns, reflects this viewpoint. Thus, the understanding of the relationship between family, child and teacher benefits not only the mental health practitioner but also benefits the child and family in providing an avenue for intervention to resolve the problems affecting the competence of the child in the classroom.

The limited definition of social competence as being based on cognitive ability alone does not recognize the impact of economic and social stress experienced as a result of poverty. Nor can the definition of social adjustment be used in isolation from other factors. As demonstrated in this project, social adjustment towards a more positive and productive relationship between teacher and child did occur according to the reported perceptions of the teachers for those children seen by the mental health treatment staff. Through the mental health consultation efforts described in this project, social adjustment seemed to occur on two levels. On one level the child and family were assessed and offered strategies for change which would impact positively on the child's opportunity and capacity for learning. On another level, the social accommodation which a teacher must assume with a new group of children with different needs and requirement, is also a function of the person-environment fit which occurs with children.

Self concept and the perceptions of one's own strengths and abilities are also a reflection of ones feeling of competence. In the educational system this perception is measured and demonstrated through academic achievement. This is the cultural context of the current educational structure. Until the time a child enters the educational system the cultural context from which a child develops is determined by the influences of the family. Achievement in many families is measured in the cultural context of the social interaction among family members. Once again, social competence is determined differently at times depending on whether the child is at home or in school. The ability to be bilingual, and the value of maintaining both the Spanish and English languages were indicative of the values to maintain a dual identity. Yet, in the context of social competence within traditional assessment methods, cognitive and social abilities reflect an Anglo cultural model of development. In this demonstration project, for example, over 63% spoke Spanish as their primary language. Nationally over 40% of the Latino population remain Spanish speaking. Another 14% indicated being bilingual, speaking English and another language. 22 percent of the population spoke English. It cannot be assumed that by definition 63 percent of the respondents are not socially competent. Rather, it must be recognized that within one culture they may be more capable then in another. Capability is not necessarily a reflection of social competence.

Physical health, for example, as a component of social competence suggests that the more physically ill or incapable one is, the less competent one may be. Physically handicapped people have been victimized as a result of this idealized interpretation of competence. Now is it recognized that physical disabilities only limit ones potential in areas where physical health becomes used as part of the criteria for competence such as the need for excellent strength as part of the job requirement. Yet physical health as a factor of high risk also suggests that the experience of health problems between the ages of birth to age 7 can contribute greatly to the potential for social competence. Poor nutrition, a lack of available health care, and a need for health education have been and continue to be areas which require assessment and intervention strategies targeted at this low income group.

Throughout this analysis, the ecological approach to the understanding, and the assessment of children and families has been emphasized. It is critical that the reader understand the process of analysis and the implementation of this approach. For example, it is just as important that intervention strategies and evaluation methods be integrated into this systemic approach as are the methods of assessment. The way a problem is assessed will determine how a problem becomes defined. The levels of assessment may be determined from the individual, group, organizational and community level. If the problem is defined as resting with the individual then the intervention strategies as well, become focused towards the individual. If the problem is identified as a group or organizational concern, then strategies of intervention will also be directed at group or systems change.

The paradigm of the socio-ecological approach to research and social intervention concerns itself with the fit between the person and his environment. From the perspective of research and analysis the concern is in understanding the interactions of these environments on the adjustment of the individual. From the perspective of social intervention, the value of the approach is with organizing environments which maximize human potential.

Although Head Start is based, in theory, on this paradigm, the focus throughout the program's development has been directed primarily at the individual child level. That is, the primary focus has been directed at the individual child level. That is, the primary focus has been directed at the improvement of cognitive abilities rather than the observed competence of the child in the classroom. Cognitive abilities of the child had, until this effort, largely become the determining factor of competence.

Families have been an integral part of the Head Start philosophy and the emphasis of components, such as Parent Involvement and Social Service, have attempted to respond on a broader systems level to this orientation.

Traditionally, however, the components have worked with parents alone in this service delivery. The MHP/IP is now recommending that all Head Start components reorient their delivery system to serve Head Start children, siblings and parents as an integral family unit. Specifically, whether a particular component works primarily with the child (Health and Education), the parents (Parent Involvement and Social Service), or with the family (Mental Health); it is time to shift attitudes where the components are aware of and serve children and parents as a family unit.

From assessment to treatment identification to outcome evaluation, the ecological dimensions which address biological, psychological, social and environmental factors, influence the potential for growth and prevention of long-range problems. All of these factors have their effect on the abilities of any child and family for a healthy and productive life.

The concept of social competence presented in this study is directly linked to the concept of mental health prevention and intervention. The promotion of positive mental health concepts and the prevention of problems through early identification indicate, as a result of the findings in this project, that social intervention with young children and families is a strategy whose time has come.

The provision of comprehensive mental health services is critical in accomplishing the primary goal of Head Start, the promotion of social competence for children and families. The full support of national policy in the areas of planning, programming and funding for mental health in Head Start with an emphasis on prevention, early identification and intervention is vital. More action is needed if mental health services are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbances through early identification and intervention. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

APPENDICES

APPENDIX 1A

Code # ____________

LATIN AMERICAN CIVIC ASSOCIATION

NEEDS ASSESSMENT CONSENT FORM

You and your family are being asked to participate in a study being conducted by the Latin American Civic Association for this school year. We are asking a parent from each family to complete a needs assessment survey at the beginning of the school year and at the end of the year before the child leaves. The teacher will ask you questions about your family's needs and your child's behavior. Please review the following points; and if you agree to this study, your signature at the bottom of the page will acknowledge that you are aware of the purpose of the study and consent to participate in this important effort.

1. I acknowledge that I have willingly participated in this survey.
2. I have been informed of my right not to answer any questions asked by the interviewer.
3. I understand that the results of this survey will be used in planning for service delivery to the children and parents of Head Start.
4. I permit the researcher to use the information I have provided with the understanding that the research will take all necessary precautions to ensure my anonymity.

____
Signature

____
Date

L.A.C.A./HEADSTART

NEEDS ASSESSMENT

____
Name of Respondent

____
Name of Child

____
Code #

____

CODE# ______________________

Interviewer: ______________________

Date of Interview: ______________________

Length of Interview: ______________________

Head Start Site: ______________________

Column

Part 1.: Family Information

To Respondent: We would like to get information on your family members, participation in your community, and any special information regarding attitudes toward your child.

1. What type of house do you live in? (check one) — 1.

____ Single family dwelling(1)
____ Duplex(2)
____ Apartment(3)
____ Mobile Home(4)
____ Other(specify) ____________(5)

2. How long have you lived at your present address? (check one) — 2.

____ Under one year(1)
____ 1 to 4 years(2)
____ 5 to 9 years(3)
____ 10 to 14 years(4)
____ Over 15 years(5)

3. How many homes has your child lived in since birth? — 3.

Number ____

If response is Under one year, skip question 4

	Column
4. Has your child adjusted to his/her new surroundings?	4.
Yes ____(1) No ____(2)	
If no, please explain ________________________________	
5. How many children in the following age groups presently live in this household?	
(Place exact number of children per age group)	
Under 5 years old ____	5.
5 to 10 years old ____	6.
11 to 15 years old ____	7.
16 to 18 years old ____	8.
None ____(1)	9.
6. How many adults age 19 and older live in this household?	10.
(include respondent) Number ____ No response ____(1)	
7. Do you feel comfortable meeting new people?	11.
Yes ____(1) No ____(2) No response ____(3)	
8. Would the idea of meeting in a group of people you don't know keep you from attending parent meetings?	12.
Yes ____(1) No ____(2) No response ____(3)	
9. Do you have family members in your community?	13.
Yes, a lot ____(1) Yes, a few ____(2) None ____(3)	
10. Do you have friends in your community?	14.
Yes, a lot ____(1) Yes, a few ____(2) None ____(3)	

Column

11. Do you belong to a prepaid health plan (Kaiser, for example)? 15.

Yes ____(1)
No ____(2)
No response ____(3)

If yes, name of group ____________________________

If no, ASK, would you be interested in low cost insurance?

Yes ____(1)
No ____(2)
No response ____(3)

Part 2: Information on Child

To Respondent: The questions in this section are designed to provide information on your child's health, sleeping habits, eating habits, and how the child is cared for at home.

12. My child is generally in good health. 16.

Yes ____(1)
No ____(2)
No response ____(3)

If no, what is your child's health problem? __________________

____

13. Has your child had a physical exam within the last 12 months? 17.

Yes ____(1)
No ____(2)
No response ____(3)

14. Is your child now on medication? 18.

Yes ____(1)
No ____(2)
No response ____(3)

If yes, what kind? ______________________
For what condition. __________________________

15. Is there a regular routine at bed time? 19.

Yes ____(1)
No ____(2)

Describe ____

Column

16. Does anyone help the child get ready for bed? 20.

Yes ____(1)
No ____(2)

If yes, who ________________________________

17. What time does your child get up during the weekday?
Check one.

Between 6 and 7 a.m. ____(1) 21.
Between 7 and 8 a.m. ____(2) 22.
Between 8 and 9 a.m. ____(3) 23.

18. What time does your child go to bed?
Check one.

Between 7 and 8 p.m. ____(1) 24.
Between 8 and 9 p.m. ____(2) 25.
Between 9 and 10 p.m. ____(3) 26.

19. Are there any special problems regarding bed time? 27.

Yes ____(1)
No ____(2)

If yes, please explain. ________________________________

20. Does your child share a bedroom with other members of the family? 28.

Yes ____(1)
No ____(2)

If yes, with whom?

21. Does your child have his/her own bed? 29.

Yes ____(1)
No ____(2)

If yes, ASK: does your child sleep in his/her own bed? 30.

Yes ____(1)
No ____(2)

If no, with whom does he/she share the bed with? ____________ 31.
(i.e. parents, brothers, sisters, etc.)

WHY? (check those that apply)

Insomnia ____(1) Nightmares ____(2) 32. 33.

Sleepwalking ____ (3) Other ____________(4) 34. 35.

Column

22. Has your child ever had any eating difficulties (poor eater, picky eater, overeating, vomiting)? 36.

Yes ____(1)
No ____(2)

If yes, please describe ____________________

23. Do you have any concerns about your child's eating habits? 37.

Yes ____(1)
No ____(2)

If yes, what concerns? ____________________

24. Are there any other special concerns about your child that I (the teacher) should be aware of? 38.

Yes ____(1)
No ____(2)

If yes, please indicate. ____________________

25. Has your child lived with someone other than his/her parents? 39.

Yes ____(1)
No ____(2)
No response ____(3)

If yes, what age ____ 40.
For how long ______ 41.
How did child react? (check all that apply)

Pleasant ____(1) 42.
Unhappy ____(2) 43.
Indifferent ____(3) 44.
Other ____(4) 45.

26. Has your child been left in someone else's care frequently? (i.e., a babysitter) 46.

Yes ____(1)
No ____(2)

If yes, at what age _____ 47.
For how long ______ 48.

How did child react? (check all that apply)

Pleasant ____(1) 49.
Unhappy ____(2) 50.
Indifferent ____(3) 51.
Other ____(4) 52.

Column

27. How does your child react when you leave him/her? (i.e., school) 53.

Protest ____(1) Cries ____(2) Is Calm ____(3) Other ____(4)

28. I feel confident I can handle most problems my child (or children) face. 54.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

29. I feel my child rearing methods/parenting skills are successful. 55.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

30. I know what's best for my child and do not seek outside advice. 56.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

31. I feel anxious that I don't know enough about child development. 57.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

32. I believe child rearing techniques/parenting skills can be changed through education. 58.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

33. As a parent, I feel my child will develop normally without constant guidance from me. 59.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

34. I would seek more educational experiences on child development in order to continue helping my child. 60.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

35. I feel the main responsibility for child rearing is with the: 61.

Mother ____(1) Father ____(2) Mother and Father ____(3) the Family Unit ____(4)

36. What benefits do you expect your child to gain from his/her Head Start experience? (list at least 5 benefits) 62.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Column

37. Is there anything on which you feel your child could use some extra help on within Head Start this year? 63.

Don't Know ____(1) No Response ____(2)

My child could use help in the following areas:

____

____

____

Part 3: Family Concerns

To Respondent: The following questions concern problems at home that could effect your child's education.

38. Do you have problems (employment, marriage, family) that come into your thoughts every day? 64.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

39. Are you satisfied with your life? 65.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

What would you like to be different?

____

40. Do you find laughter comes easily to you? 66.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

41. Do you ever feel like crying and you're not sure why? 67.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

42. Do you have arguments or disagreements in the family? 68.

Always ____(1) Sometimes ____(2) Seldom ____(3) Never ____(4)

43. When the adults in the family argue or disagree, what does your child do? 69.

Cries ____(1)Hides ____(2)Ignores us ____(3)Gets angry ____(4)

Column

Part 4: Service Utilization

To Respondent: The following questions are designed to provide information on your use of social services, how you cope with problems and the type of information we could provide you with in helping you to resolve your problems.

44. Do you have any worries which you would want to see a counselor or parent educator about? These problems could be associated with: 70.

Housing ____(1) Social Services ____(2) Child Rearing ____(3)

Family Problems ____(4) Other ____(5) ____________________

45. To whom do you prefer to talk to about your worries? 71.

Spouse/live-in partner ____(1) Friend ____(2) Relative ____(3)

Child ____(4) Other ____(5) ________________________

46. How do you cope with problems in your family? 72.

Take action to solve problem ____(1)

Ignore it, let someone else handle it ____(2)

47. Do you know the following agencies? (check all that apply)

	YES	NO	
Manos de Esperanza	____	____	73.
Centro de Amistad	____	____	74.
San Fernando Valley Child Guidance Clinic	____	____	75.
Friends of the Family	____	____	76.
Family Connection	____	____	77.
Coldwater Canyon Hospital	____	____	78.
Dept. of Social Services	____	____	79.
Alcoholics Anonymous	____	____	80.
Nar-Anon	____	____	81.
Family Service of Los Angeles	____	____	82.

Others ____(1) 83.

____(1) 84.

____(1) 85.

Column

47. (cont) If respondent answers yes to any of the above, ASK: How did you find out about the program? ____________

____

48. Have you used any of the above services? 86.

Yes ____(1)

No ____(2)

No response ____(3)

49. Would you use any of the above services? 87.

Yes ____(1)

No ____(2)

No response ____(3)

CODE # ____________

53. The Head Start agency provides help/and or referrals with the following services. Check all that apply.

ITEM	Need Information	Have Utilized in Past Year	Need for Service Now	Column
Family Relations				
Spouse Abuse	________(1)	________(2)	________(3)	88.
Child Abuse	________(1)	________(2)	________(3)	89.
Alcohol/Drug	________(1)	________(2)	________(3)	90.
Psychological Services	________(1)	________(2)	________(3)	91.
Crisis Intervention	________(1)	________(2)	________(3)	92.
Emergency Services				
Medical Needs	________(1)	________(2)	________(3)	93.
Shelter	________(1)	________(2)	________(3)	94.
Food	________(1)	________(2)	________(3)	95.
Clothing	________(1)	________(2)	________(3)	96.
Counseling				
Family Needs	________(1)	________(2)	________(3)	97.
Individual Needs	________(1)	________(2)	________(3)	98.
Economic Factors				
DPSS Problems	________(1)	________(2)	________(3)	99.
Financial Needs	________(1)	________(2)	________(3)	100.
Employment	________(1)	________(2)	________(3)	101.
Housing Needs	________(1)	________(2)	________(3)	102.
Legal Issues				
Legal(general)	________(1)	________(2)	________(3)	103.
Immigration	________(1)	________(2)	________(3)	104.
Education				
Education as a Second Language	________(1)	________(2)	________(3)	105.
Adult Education	________(1)	________(2)	________(3)	106.
Vocational	________(1)	________(2)	________(3)	107.
Translation	________(1)	________(2)	________(3)	108.

Child's Name ________________________________

Parent's Name ________________________________

Site/Class ________________________________

APPENDIX 1B

CODE # ____________

Family Social Competence Scale

DIRECTIONS: To Respondent

The following are a number of statements about which there is no general agreement. People differ widely in the way they feel about each item. There are no right answers. The purpose of the survey is to see how different individuals feel about each item. We would like your honest opinion on each of these statements. Whenever possible, let your own personal experience determine your answer. Do not spend much time on any item. If in doubt, select the phrase that seems most nearly to express your present feeling about the statement.

To Interviewer:

READ EACH ITEM AND CHECK QUICKLY THE PHRASE THAT BEST EXPRESSES THE RESPONDENT'S FEELING ABOUT THE STATEMENT. WORK RAPIDLY. BE SURE TO ANSWER EVERY ITEM.

Column

1. I prefer to speak and write in English. 109.

   Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

   Disagree ____(4) Strongly Disagree ____(5)

2. It is important to be able to use two languages (for example, English and Spanish) in order to participate fully in society. 110.

   Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

   Disagree ____(4) Strongly Disagree ____(5)

3. It is important for a non-English speaker to strive and learn English and not forget their native language. 111.

   Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

   Disagree ____(4) Strongly Disagree ____(5)

4. The wellbeing of one's family is a responsibility all parents must accept. 112.

   Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

   Disagree ____(4) Strongly Disagree ____(5)

5. When we are short on money it is important to insure that food is on the table for the children. 113.

   Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

   Disagree ____(4) Strongly Disagree ____(5)

Column

6. As long as we have a place to sleep, it is not necessary to worry about other problems. 114.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

7. It is important to use money for family purposes rather than for personal enjoyment. 115.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

8. Contributing to the support of others displays a concern for members of one's community. 116.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

9. Giving personal or financial support to the church, schools, and civic groups contributes to the social wellbeing of the community. 117.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

10. If we had the money, we would put it aside in a savings to help create a future for our children. 118.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

11. I believe my child should graduate from high school and find a job. 119.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

12. I believe my child should go to college. 120.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

13. I enjoy spending time with my family when not working. 121.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

Column

14. People rely on me in terms of need or in emergencies. 122.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

15. It is important to participate in educational programs if it means improving my child's educational experiences. 123.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

16. If necessary, I will create my own opportunities (i.e., employment) as a means of helping my family. 124.

Strongly Agree ____(1) Agree ____(2) Undecided ____(3)

Disagree ____(4) Strongly Disagree ____(5)

THANK YOU FOR YOUR COOPERATION

APPENDIX 1C

MHP/IP

POST ASSESSMENT

Name of Respondent

____

Name of Child

____

Interviewer: ________________

Date of Interview: ________________

Length of Interview: ________________

Head Start Site: ________________

DIRECTIONS: Please answer the following questions yes or no. If the respondent does not wish to answer the question, check no response.

	Column
1. Have you applied for health insurance in the past year? Yes ____(1) No ____(2) No response ____(3)	1.
2. Is your child in good health? Yes ____(1) No ____(2) No response ____(3)	2.
3. Has your child had a physical exam or been ill within the last month? Yes ____(1) No ____(2) No response ____(3)	3.

	Column
4. Has your child been ill within the last 12 months?	4.
Yes ____(1)	
No ____(2)	
No response ____(3)	
5. In the past year, has your child lived with someone other than his/her parents (other family members)?	5.
Yes ____(1)	
No ____(2)	
No response ____(3)	
If yes, at what age? ____	6.
For how long? ____________________(indicate month or year)	7.
How did child react? (check all that apply)	8.
Pleasant ____(1)	9.
Unhappy ____(2)	10.
Indifferent ____(3)	11.
Other ____(4)	
6. In the past year, has your child been left in the care of a babysitter?	12.
Yes ____(1)	
No ____(2)	
No response ____(3)	
If yes, at what age? __________	13.
For how long? _________________ (indicate month or year)	14.
How did child react? (check all that apply)	
Pleasant ____(1)	15.
Unhappy ____(2)	16.
Indifferent ____(3)	17.
Other ____(4)	18.

3 4

Column

7. In the past year, have there been any worries that have caused you to see a counselor or think about seeing one? 19.

Yes, I saw a counselor ________________(1)

Yes, I thought about seeing a counselor _______________(2)

No __________(3)

No response ___________(4)

8. Have you received assistance from LACA/Head Start? 20.

Yes __________(1)

No ___________(2)

No response ___________(3)

If yes, from which of the following components? 21.
(check all that apply) 22.

Education ______(1) Health ______(2) 23.

Parent Involvement ______(3) Social Service ______(4) 24.

Mental Health ______(5) Handicap ______(6) 25.

DIRECTIONS: Please answer the following questions by checking only one of the following responses. 26.

9. I know what's best for my child and do not seek advice. 27.

Strongly agree ____(1) Agree ____(2)

Undecided ____(3) Disagree ____(4) Strongly Disagree ____(5)

10. I believe my child should graduate from high school and find a job.

Strongly Agree ____(1) Agree ____(2) 28.

Undecided ____(3) Disagree ____(4) Strongly Disagree ____(5)

	Column
11. I believe my child should go to college. Strongly agree ____(1) Agree ____(2) Undecided ____(3) Disagree ____(4) Strongly Disagree ____(5)	29.
12. I would seek more educational experiences on child development in order to continue helping my child. Strongly agree ____(1) Agree ____(2) Undecided ____(3) Disagree ____(4) Strongly Disagree ____(5)	30.

THANK YOU FOR YOUR COOPERATION

APPENDIX 1D

LATIN AMERICAN CIVIC ASSOCIATION
State Preschool/Head Start

MENTAL HEALTH CLASSROOM OBSERVATION/SUPERVISION CYCLE

AGENCY NAME: ______________________________ OBSERVATION DATE: ____________________

SITE NAME: ______________________________ TIME: __________ TO: _______________

OBSERVER: ______________________________ TEACHER PRESENT: ____________________

OBSERVATION:

1. Activities in Progress

2. General Learning Environment

Mental Health Classroom Observation/Supervision Cycle
Page 2

AGENCY NAME: ____________________ SITE NAME: _______________ OBSERVATION DATE: __________

3. Interactions (adult, child-child, adult-child)

4. Other

RECOMMENDATIONS:

I have consulted with teaching staff and others as appropriate regarding these observations and recommendations.

____ ____________________
Signature of Mental Health Professional Date

APPENDIX 1E

TO: CDS/Teaching Staff

FROM: Mental Health Component

SUBJECT: Teacher Feedback-Mental Health Observation/Supervision Cycle

Since Mental Health has participated in the Observation/Supervision Cycle your comments/suggestions will help us to determine the effectiveness of our services. We need to know specifically if and how this was helpful to you; was it beneficial for you in dealing with the children in the classroom; and what kind of improvement can be made to providing a more qualitative Observation/Supervision Cycle.

Your response to this as soon as possible is greatly appreciated.

Use both sides of page if necessary

Teacher: ____________________ CDS: ________________

Site: ______________________ Date: _______________

APPENDIX 1F

MENTAL HEALTH INDIVIDUAL CHILD OBSERVATION/ACTION PLAN

SITE: ______________________ DATE: ______________________

CLASS: ______________________ OBSERVATION OF: ______________

TEACHER: ______________________ OBSERVATION BY: ______________

TEACHER ASSISTANT: ______________________________________

PRESENTING PROBLEM: ______________________________________

OBSERVATION: ______________________________________

ACTION PLAN: ______________________________________

INITIAL T. ____
INITIAL TA. ____
INITIAL MH. ____

APPENDIX 1G

MHP/IP PARENT EVALUATION OF MENTAL HEALTH

Name of child: ____________________________

Site: ________________________ Class: ______________________

Name of parent: ____

Name of Counselor: ____

Name of Interviewer: _______________________________________

1. Do you feel the treatment provided by Mental Health has been of help to you? yes ____ no ____ undecided ____

   Please explain: ____

   ____

   ____

2. What things helped you the most in counseling? ______________________

   ____

   ____

3. Was the therapist helpful? yes ____ no ____

   Explain: ____

   ____

4. What things did you not like about our services? ____________________

   ____

   ____

5. Are there any suggestions you have that can be of help to us in making our services better in the coming year? yes ____ no ____

   Please explain: ____

   ____

   ____

   ____

APPENDIX 1H
MHP/IP INTAKE FORM
CONFIDENTIAL

CODE # ____________________
(FOR OFFICE USE ONLY)

COUNSELOR: ________________

DATE: ________________

Child's Name ____
LAST FIRST MIDDLE

PARENTS:	MOTHER	FATHER
NAME:		
ADDRESS:		
PHONE:		
AGE:		
BIRTHDATE:		
MARITAL STATUS:		
ETHNIC BACKGROUND:		
EMPLOYMENT HISTORY:		
CURRENTLY EMPLOYED:		
WEEKLY SALARY:		
TYPE OF WORK		
P/T - F/T		
SOURCE OF INCOME		
(See instructions)		
EDUCATIONAL HISTORY:		
CURRENTLY IN SCHOOL:		
HIGHEST GRADE COMPLETED:		
VOCATIONAL PROGRAM:		
TYPE OF PROGRAM:		

PRESENTING PROBLEM:

FOR CHILD:

____(01) Behavior ____(02) Short Attention Span ____(03) Phobias ____(04) Abuse
____(05) Depression ____(06) Teacher ____(07) Other ____________________

FOR FAMILY:

____(08) Marital Problems ____(09) Depression ____(10) Alcoholism
____(11) Divorce/Separation ____(12) Child Abuse ____(13) Death
____(14) Parenting Education ____(15) Domestic Violence ____(16)Drugs
____(17) Other ______________________________

Reason for Referral: ______________________________________

APPENDIX 1I

MHP/IP
CASE SUMMARY

AREA: __________

SITE: __________

CLASS: _________

CODE # ____________________
(FOR OFFICE USE ONLY)

Column ____________________

1. Name of child ____
Last First

2. Name of parent:

mother or __________ ________________________________
Last First

father or __________ ________________________________
Last First

3. Name of counselor ________________________________

4. Referral number __________________

5. Length of treatment: (# of wks f/assigned date to closing)
____________ 1.

6. Number of sessions held ________ 2.

7. Number of cancellations ________ 3.

8. Number of no-shows ___________ 4.

9. Number of sessions of each: family ___(1) individual ___(2)
conjoint ___(3) play ___(4) 5.

10. Language of parents (check one): monolingual Spanish ___(1)
bilingual English/Spanish ___(2) monolingual English ___(3)
monolingual other (explain) __________(4) Bilingual English/
other (explain) ________________(5) 6.

11. Reason for referral ____ 7.
____

12. Referred by: teacher ___(1) support staff ___(2)
parent ___(3) 8.

Column

13. Is family: intact ____(1) S.P. father ____(2) 9.
S.P. mother ____(3)

14. If intact family, how many sessions did both parents 10.
attend? ________

15. Check original presenting problem (check one) for child: 11-12
separation ____(01) aggressive behavior ____(02) withdrawn
behavior ____(03) non-responsive behavior ____(04) short
attention span ____(05) phobias ____(06) depression ____(07)
speech ____(08) developmental delay ____(09) inappropriate
developmental behavior ____(10) other ____(11) explain

____

____

16. Check original presenting problem for family (check one) 13-14
marital problems ____(01) separation/divorce ____(02)
lack of parenting skills ____(03) death ____(04)
depression ____(05) systemic dysfunctional communication
____(06) domestic violence ____(07) drugs ____(08)
child abuse (physical) ____(09) child abuse (sexual) ____(10)
alcohol ____(11) individual unresolved issues ____(12)
other ____(13) explain: ____________________________

____

____

17. Check presenting problem after assessment of child (check one) 15-16
separation ____(01) aggressive behavior ____(02) withdrawn
behavior ____(03) non-responsive behavior ____(04) short
attention span ____(05) phobias ____(06) depression ____(07)
speech ____(08) developmental delay ____(09) inappropriate
developmental behavior ____(10) Other ____(11) explain:

____

____

____

	Column
18. Check presenting problem after assessment of family (check one) marital problems ____(01) separation/divorce ____(02) lack of parenting skills ____(03) death ____(04) depression ____(05) systemic dysfunctional communication ____(06) domestic violence ____(07) drugs ____(08) child abuse (physical) ____(09) child abuse (sexual) ____(10) alcohol ____(11) individual unresolved issues ____(12) other ____(13) explain: ______________________________ ____ ____	17-18
19. Has child/family: received or in process of receiving treatment ____(1) dropped from program ____(2) original presenting problem was resolved before the time of initial contact ____(3) parents refused/resistant to treatment ____(4) referral inappropriate ____(5)	19
20. How far did this case go in each of the following stages? Check all that apply: case assigned ____(01) teacher contact ____(02) classroom observation ____(03) adult contact ____(04) parent/teacher conference ____(05) preliminary interview ____(06) screening interview ____(07) staffing/treatment plan ____(08) interpretive session ____(09) treatment ____(10) teacher education ____(11) parent education ____(12) case closing ____	20-21 22-23 24-25 26-27 28-29 30-31 32-33 34-35 36-37 38-39 40-41 42-43 44-45

Column

21. What treatment goals were established by therapist to resolve clients problem: ______________________________ 46.

____

____

____

____

22. Did treatment goals help to alleviate the presenting problem? yes ____(1) no ____(2) explain: ____________ 47.

____

____

____

____

23. If treatment was started but terminated before completion, what was the reason? Check all that apply: client terminated services ____(1) client moved ____(2) child dropped from program ____(3) other ____(4) explain: ____ 48.

____

____

____

____

24. Was decision to terminate: mutual ____(1) client's choice ____(2) therapist decision ____(3) other ____(4) explain: ____ 49.

____

____

25. Final review (8 week or ____ wk follow-up teacher: problem resolved yes ____(1) no ____(2) ____________________ 50.

____

____

____

Column

26. Parent: problem resolved yes ____(1) no ____(2) 50.

____

____

____

____

27. Who does the child live with: both biological parents ____(01) one biological parent & significant other ____(02) only mother ____(03) only father ____(04) two foster parents ____(05) foster mother ____(06) foster father ____(07) two grandparents ____(08) grandmother ____(09) grandfather ____(10) relatives ____(11) Other ____ (12) explain: ______________ 52-53

____

____

Name of child: ____________________

NARRATIVE

APPENDIX 2

LATIN AMERICAN CIVIC ASSOCIATION

STATE PRESCHOOL/HEAD START
1248 KEWEN STREET
SAN FERNANDO, CALIFORNIA 91340
361-8641

REFERRAL FOR SERVICES

DATE ____________________

TO: SOCIAL SERVICE ____________ MENTAL HEALTH ____________ HANDICAPPED ____________

HEALTH ________________ NUTRITION ______________ PARENT INVOLVEMENT __________

CHECK ONE: (IF REFERRAL IS NEEDED TO AN ADDITIONAL COMPONENT, COMPLETE SEPARATE FORM)

CHILD'S NAME __________________________ PARENT'S NAME ____________________________

DATE OF BIRTH __________________ SEX ______________ PHONE # ____________________

ADDRESS __________________________ CITY ______________________________ ZIP ________

LANGUAGE SPOKEN: CHILD/PRIMARY _________________________ OTHER ____________________

LANGUAGE SPOKEN: FAMILY/PRIMARY ________________________ OTHER ____________________

MEDICAL INSURANCE: MEDI-CAL ____________________________ OTHER ____________________

PERSON REFERRING: _______________ TITLE _______________ SIGNATURE _______________

SITE: ________________________ CLASSROOM _______________ TEACHER _______________

REASON FOR REFERRAL ____

____

____

HAVE YOU DISCUSSED THIS WITH THE FAMILY? (please explain) ____________________________

____

DO YOU KNOW OF ANY OTHER SERVICES OR COMPONENTS THAT HAVE BEEN INVOLVED IN THIS CASE?

____

OFFICE USE: DATE RECEIVED: ________________
ACTION PLAN:

________________ ________________________________
DATE COMPONENT SUPERVISOR'S SIGNATURE

APPENDIX 3

Mental Health Classroom Observation Questions

1. The age appropriateness of the child's play. Is it parallel type, interactive and cooperative, and able to carry on a theme? Is the child interacting with others at all or is he/she withdrawn?
2. The interaction pattern with teachers. How does the child respond to directions given? Is he/she able to listen or does he/she seem withdrawn in his/her own inner world?
3. How does the child approach material given him/her; enthusiastically or with trepidation? What is the quality of use of play material; is there an inclination towards destructiveness? Is there difficulty in engaging with materials?
4. Group time. Is the child able to sit with the other children without excessive fidgeting, poking, talking? What is the quality of attention given to the teacher?
5. Outside play time. Does the child play with other children or alone? How does he/she use the play materials, equipment? The counselor should be aware of the level of energy the child uses; is he/she active or lethargic, aggressive, fearful, delayed, etc.

APPENDIX 4

Preliminary Interview Questions

1. Mental Health counselor asks parents to sign the Consent for Treatment form.
2. Child: What is the presenting problem?
    a. What is the complete history of the presenting problem?
        (1) noticed symptoms
        (2) problem before symptoms
        (3) other people's comments on child's behavior
    b. Trace history of the child from session to birth.
        (1) developmental milestones (birth, walking, talking, toileting)
        (2) behavioral history (temperament, response--response to peers, adults, teachers, parents)
        (3) history of geographic changes (cause for change; were both parents included in change)
3. Significant people in child's life--who cares for the child? (cover each one separately)
    a. Parents
    b. Babysitter
    c. Maternal and paternal grandparents
    d. Other relatives
    e. Live-in friends
    f. School
4. Parent's relationship
    a. How long have they been married?
    b. Why did they get married?
    c. What problems do they have?
    d. Does Mom work?
    e. Did they want to have children?

APPENDIX 4 (continued)

5. Parents. (cover each one separately.)
   a. Child's family and each parent's family.
      (1) their mother and father
      (2) how did their parents handle their differences (affectionate, fighting, absent parent?)
      (3) brothers and sisters (how did they get along? rivalry, alliances
      (4) what was it like growing up in their families?
      (5) were grandparents involved?
      (6) what are all other members of family doing and what are their current family situations?

   What does each parent do as an avocation?
      (1) work schedule
      (2) home schedule
      (3) what were the children told?
      (4) how do they feel about it?
      (5) do the parents get along?
      (6) etc.

APPENDIX 5

Parent Education/Training Sessions Curriculum

Objectives for Parent Education Sessions (conducted in English and Spanish):

(1) Understanding Child Development -

Familiarize parents with the development of the young child. Focusing on the findings of Erickson and Piaget with emphasis on the cultural aspects of the community.

(2) Separation Anxiety for Parent and Child -

Explain the social and emotional developmental needs of the young child entering preschool emphasizing the separation process.

(3) Emotionally Healthy Children -

Identify the important aspects of emotional health in children and discuss specific ways for parents to encourage and support development of positive feelings and attitudes in their children.

(4) Importance of Play -

Define the concept of play as the child's work; how play influences and builds the child's social, cognitive, language and motor skills and the development of problem solving strategies and creativity through play.

(5) Conflict Management -

Present techniques for establishing realistic and helpful behavioral goals for children.

(6) Problems of Being a Parent -

Provide an opportunity for parents to discuss feelings and problems in a supportive environment. Topics may include: discipline, tantrums, why children's logic is different from adults, and children's fears.

(7) Enhance Social Competence in Parents -

Strategies for parents in building self-help, problem solving and communication skills.

Appendix 6

Samples of Treatment Case Summaries

The following 7 case summaries are presented to demonstrate some of the type of problems that were seen and ways treatment was carried out. The first 5 cases were successful and the last 2 were unsuccessful.

Case #1

Robert T. had been physically abused and emotionally neglected and is presently living in a foster home.

Robert T., 3 years and 5 months old was referred by his teacher because of a past history of neglect and abuse. He was taken away from his biological mother at 2 years 11 months of age and placed in the foster care of Catherine M. Robert was experiencing pervasive developmental delays such as sudden excessive anxiety manifested by catastrophic reactions to everyday occurrences, inability to be consoled when upset, unexplained rage reactions, inability to maintain meaningful contact with adults and peers, resistence to change in environment, speech delays and nightly head banging. He was referred to Regional Center to accept him as a client. These delays were a result of the neglect and abuse he received in the first 3 years of his life. Through therapy, the foster mother became aware of the origin of Robert's problems and the need for her to provide him with a loving, supportive and stable environment. Mental health trained the foster mother to handle Robert's erratic behavior.

Through teacher education, the teachers understood the need to provide Robert with a loving, supportive and stable environment. They are assisting him with having meaningful contact with adults and peers. Teachers were consistent in their handling of his disruptive behavior in the classroom. Simultaneously he was receiving speech therapy twice a week. Mental health connected with the adoptions case worker and explained Robert's problems and the work that mental health was doing to assist him. As a result the adoptions case worker understood the extent of Robert's problems and will be aware of this when she is looking for a placement for him and will also require the adoptive parents to continue psychological and speech therapy for him. As a result of the therapist's work, and parent and teacher education, Robert is able to initiate and maintain meaningful relationships with adults and peers. Most of the excessive anxiety that he manifested has been alleviated. He appears calm, an inner sense of self-esteem and independence have developed. Much of his nightly head banging has been alleviated.

Case #2

This family was under extreme stress due to an auto accident a number of years ago that left one of the children handicapped and brain damaged.

David V., 4 years and 6 months old, was referred by his teacher for having unclear speech and aggressive behavior. One of David's siblings, Thomas, was hit by a car 5 years ago and as a result is severely handicapped. He has brain damage, severe speech problems and uses a wheelchair or a walker for mobility. Mrs. V. stated that John, her oldest son appeared depressed and was having academic problems at school and that her daughter Kathy was not very communicative with her and appeared withdrawn. The family included Mr. V. (31), Mrs. V. (28), John (12), Thomas (10), Kathy (8), and David (4). Due to long term unresolved problems Mr. V. and Mrs. V. were experiencing marital problems. Mrs. V. presently was making threats of divorce to Mr. V.

Through therapy, both parents recognized that they never talked about the accident with their family and that Mrs. V. was giving more privileges to David for being the youngest. David used to play with Thomas for long periods of time and he was imitating his handicapped brother in his speech.

There was a severe lack of communication in this family and an aura of secrecy concerning the accident. John witnessed the accident and because he was Thomas' older brother and was told to watch him, he experienced severe guilt feelings that he should have been able to save his brother. John was able to resolve his guilt through play therapy with David, he was able to realize that Thomas' problems and speech were a result of the accident. Through therapy with Mrs. V. and Kathy we worked on how Kathy's fears of being scolded by her mother closed the communication between them. Through play therapy with Thomas what happened in the accident was discussed. His strengths were stressed to increase his low self-esteem. Through therapy, Mr. and Mrs. V. began to deal with their unresolved long term problems, increasing the communication between each other and with the family.

Mr. and Mrs. V. resolved their individual problems and improved communication between them; Thomas' self-esteem increased; John's guilt resolved, he was showing improvement at school and appeared to be much happier. The communication between Mrs. V. and Kathy improved and David's teacher said that his aggressive behavior had stopped and his speech was age appropriate.

Case #3

This case involves a child who was hospitalized as an infant for an overdose of angel dust and whose younger sister was born addicted to heroin.

Sal O., 5 years and 1 month old, was referred by the Child Development Supervisor because he was hospitalized at 13 months for an overdose of angel dust. Since then, Sal was living with his grandmother who had legal custody, because his mother was on drugs and his father was in jail. Sal was bedwetting; he appeared insecure, and had difficulty interracting with peers. The grandmother's family included Mrs. O (53) and her three daughters (19, 18 and 16 years). Sal's mother, 26 years old, was living with her boyfriend. Recently she had a baby girl who was born addicted to heroin. For this reason the baby was living with her mother's uncles who had legal custody of the baby.

Through therapy it became clear that there was a severe lack of communication in Sal's family. Sal did not know why and for how long he would be living with his grandmother or where his father was. Sal was told erroneously that his little sister was living with his mother. During therapy it became clear that the severe lack of communication was increasing Sal's feelings of being unloved and abandoned. His grandmother did not know how long Sal was going to live with her. When his mother visited Sal she was telling him that very soon he was going to live with her and his sister. Working with the grandmother and mother individually they began to tell Sal the same information. They explained to him why Sal was living with his grandmother, where Sal's father was, and that Sal's mother was not living with the baby.

Sal's mother was regularly attending a detox program, she began to abstain from drugs and she started visiting Sal regularly. Through our therapy the mother and grandmother realized that their anger towards each other was confusing to Sal and causing the child anxiety. Due to Sal's mothers' sobriety, she regained permission to take her child to her house during the week-ends. She is trying to build a close relationship with her son in order to get custody again.

Through play therapy Sal's feelings of being unloved and abandoned were explored and he was able to express his anger as a result of therapy. Sal was talking freely at school about his mother and father. He appeared happier and confident as a result of this he is successfully relating to peers.

Because the significant adults in Sal's life have taken responsibility in providing a stable and nurturing home environment for him he is more secure, he is able to appropriately relate to adults and peers and his bedwetting has decreased.

Case #4

This case involves twins who were separated from their mother at birth and were not reunited until they were 3 years old.

Jessica and Janet V. 4 years and 3 months old, were referred by the teacher because their mother needed help with the twins as a result of the past history of separation from them. Obeying her mother's wishes, Ms. V. had given away her twins to her married sisters, because she was a 16 year old unwed mother when she had them. After 3 years, both sisters separated from their husbands and the twins were returned to their mother who by then lived with her boyfriend who was the father of the youngest sibling. At the time of the referral the family consisted of Ms. V. (21), her live in boyfriend and father of Terry, Mr. J. (38), Jessica, Janet, and Terry, their 2 year old half sister. Ms. V. felt overwhelmed with the situation. The twins were dependent and insecure. Ms. V. felt that Jessica was selfish, aggressive and disobedient and she had a hard time feeling she loved the twins like she loved Terry and was feeling guilty about it. Ms. V. also believed the twins should look and act alike. Treatment goals were established to help Ms. V. accept and allow different identities for the twins; to give her and Mr. J. an understanding of developmental stages; to explain to the twins their history of separation; explore with them their feelings of insecurity and loss; and reassure them about a stable future; to help Ms. V. with her individuation and growth process and finally to explore and resolve issues of favoritism among the 3 children.

During therapy, Ms. V. was able to explore her feelings of guilt towards abandoning the twins; she resolved this guilt and was then able to feel her natural feelings of maternal love for them. Jessica and Janet lost their dependent and whining behavior in class and were able to separate in a very appropriate way from their mother when she had to leave for a 4 day trip. Ms. V. took the necessary steps to differentiate the twins and understood the importance of allowing them separate identities. As a result of changes in therapy, Ms. V. initiated resolving conflicts with various members of her family, establishing for herself a new position as a young adult, capable of making decisions for herself. Consequently Ms. V's. self-esteem was enhanced and this allowed her to take new steps in her relationship with her boyfriend. She felt very secure and competent in her maternal role and established specific goals to plan to go to school to become a teacher. As a result of therapy Jessica was doing very well in school, being very independent, not clinging to adults and separating well from her mother.

Ms. V. said the twins were very independent; wanted also to do some things separately, have different hair cuts, etc.; Ms. V. increased her parenting skills, increased her self-esteem and was able to express herself with her relationship with her children, her boyfriend, and her family.

Case #5

This family was experiencing stress due to 3 of the children's prolonged separation from their mother. While they remained in El Salvador, their mother went to the United States, married and had twins. Conflicts arose when the families were reunited.

Jorge L., age 4 years and 7 months was referred by his teacher because of short attention span, withdrawn behavior and low developmental inventory scores. He lived with his parents, 3 half-brothers (16, 12, and 11 years), and his twin sister, Crissy.

During therapy it became clear that Jorge's problems were stemming from a crisis in the family centered around the 16 year old son. There was severe tension between the stepfather and this son. The son resented how he and his brothers were being treated by the stepfather. He gave preferential treatment to his own children, the twins. The son also harbored anger towards his mother who had left him and his 2 siblings in El Salvador for 5 years with his grandmother when he was 7 years old. His anger manifested itself by the son's attempt to fondle the mother's legs and genital area while she was asleep.

Through therapy, family conflicts were openly discussed. The parents became aware of how their responses to their son were causing him to feel isolated and to seek out alcohol and marijuana for relief. The mother and son were able to discuss the sexual overtures the son had made, and discuss possible causes and solutions. In addition to the stress Jorge's was experiencing as a result of the family dynamics, he had learning disabilities in terms of auditory processing, fine motor development, and visual tracking. An IEP was done by the handicap component.

As a result of therapy the family had a clearer idea of what steps could be taken to deal with conflicts. For the first time the son was able to verbalize his deep-seated anger and resentment. The mother and son made a committment to continue with long term therapy at an outside agency. As a result of the decrease in family tension, Jorge was interracting and functioning more appropriately with peers and adults in the classroom.

Case #6

This case involves a family going through a separation where the father is against the separation and is trying to regain his position in the family.

Susy P., 4 years and 10 months old, was referred by her teacher because she had a lack of comprehension in both English and Spanish; poor attention span and poor story recall. Mrs. P. said she had poor communication with her daughter and that she needed some parent education in order to understand Susy's needs. The family included Mrs. P. (28), Susy, and a 3 and one half year old daughter. Susy's parents had been separated for 6 months, due to lack of communication between each other and physical fights between them. Frequently Mr. P. drank and used to hit Mrs. P. in front of the children. In spite of the fact that Susy and her sister knew about their parent's separation they never talked with their mother about the fights and arguments they had witnessed in the past.

Since he left home, Mr. P. had visited his daughters regularly. Sometimes he remained in the house to have dinner or he went out during the weekends with his ex-wife and daughters as if they were not separated. During therapy it became clear that Mrs. P. was repeating her own past history in the present. She married an impulsive man and she separated from him later, as her mother had done. Due to the fact that she was abandoned by her mother she did not have a good model at home which might have influenced her relationship with her own children. Mrs. P. was almost abandoning her children, leaving them with the babysitter because she had to work hard. It was hard for her to spend some individual time with them after work. As a result of that, Susy was very isolated at home, refusing to communicate or play with her mother.

In spite of Mr. and Mrs. P.'s marital discord, Mr. P. was a warm and communicative father, who had a good relationship with his daughters. He did not want to be separated from Mrs. P. and he used to be at his children and ex-wife's home as if she weren't divorced, confusing the children and Mrs. P. too. Marital counseling was offered to the couple but Mrs. P. refused it. She did not want to get back with her ex-husband and she did not want him to build some expectations through the counseling. She did not understand that the counseling did not mean that she had to go back to living with her husband.

During therapy, Mr. P. could not understand that his behavior was confusing his family because of his violence with his ex-wife. One week before the treatment ended, Mr. P. hit his wife again, in front of the children, because she went out to a party without his permission. At that time, Mr. P. realized that he needed individual therapy and that he was not only confusing his family with his separation but deceiving himself as well.

Case #6 (continued)

Through our sessions Mrs. P. was able to work through her feelings of being abandoned by her mother in the past and she developed parenting skills. She realized the importance of spending special time with Susy and she began to talk about the domestic violence Susy had witnessed in the past. It was clear that Susy's lack of comprehension and short attention span were related to all the stress she had gone through in the past.

At home Susy's verbal skills have increased and a nurturing and supportive relationship developed between the child and her mother.

Susy's teacher stated that Susy improved during the first week of treatment, becoming more communicative and more in touch with reality, but she regressed to her former behavior later. This occurred when domestic violence started over again at home.

Case #7

This is a case of a child who appeared disconnected to reality and whose parents' refused to participate in therapy.

Carmen P., 4 years and 6 months old, was referred by her teacher because she appeared disconnected to reality. When the teacher asked her questions Carmen was very distracted as if she was in another world. She was disobedient and very aggressive. Carmen watched t.v. the entire day and when Mrs. P. turned off the t.v., Carmen threw things at her and screamed so loudly that her mother let her have her way and continue to watch t.v. At home, Carmen refused to play with her siblings. She watched t.v. and played by herself. The family included Mr. P. (27), Mrs. P. (22), Carmen (4), a 3 year old daughter and a 2 year old son.

Although Mrs. P. recognized her daughter's problems, she never came to therapy. Due to her resistance to treatment, the counselor went to the home. During the visits, it became clear that Mrs. P. did not maintain the authority role, she was not setting appropriate limits, she was not consistent with the directions that she was giving to her children and her household was very disorganized. The children did not have a set time to eat, sleep or take a bath. All three children were rude with their mother and refused to follow her directions.

Mrs. P. stated that it was hard for her to set limits because her husband did not agree with her on this point. Mr. P. had different age appropriate behavior expectations, thinking that his children were too young to be disciplined. He was never disciplined as a child as a result he was parenting his children this way. For the last two years Mr. P. had been unemployed and was having extremely severe financial problems. Because they had not paid the rent of the apartment for the last two months, they were being taken to court.

Carmen appeared to be a smart child, who preferred to be disconnected to reality as a defense to protect herself from such a chaotic and disorganized family situation. Carmen was more connected to the t.v. than to her mother, who due to her ambivalence used to give double messages to her children. Mr. P. was always threatening the children and not following through on the threats; she had difficulty taking the parental role, and in order to avoid fights among the children she did not allow her children to share their toys. There was extensive sibling rivalry among the children.

Through the visits, Mrs. P. realized that she lacked parenting skills and she also recognized that with her double messages and threats, she was confusing her children. After two home visits Mrs. P. began to communicate with her children instead of turning on the t.v. as she had done before to calm down her children. Mr. P. refused to participate in any of the home visits because he denied that any problem existed. Because of the parents' resistence to treatment, extensive teacher education was undertaken to provide Carmen with an emotionally supportive

Case #7 (continued)

classroom environment. Treatment is far from complete because of Mr. and Mrs. P.'s resistence. Carmen still does not appear to understand some of her teacher's questions although her connection to reality has increased. Carmen is spending more time playing with friends and less time watching t.v., but the family needs further treatment in order to promote Carmen's connection to reality. The parent's need to acknowledge the existing problems and take responsibility to resolve them if any substantial changes are to be made in the family.

This case was referred to mental health late in the year. Mental Health referred this case to the Handicap Component for extensive psychological testing but because it was so late in the year Handicap was not able to do the testing and referred the parents' to an outside mental health agency.

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